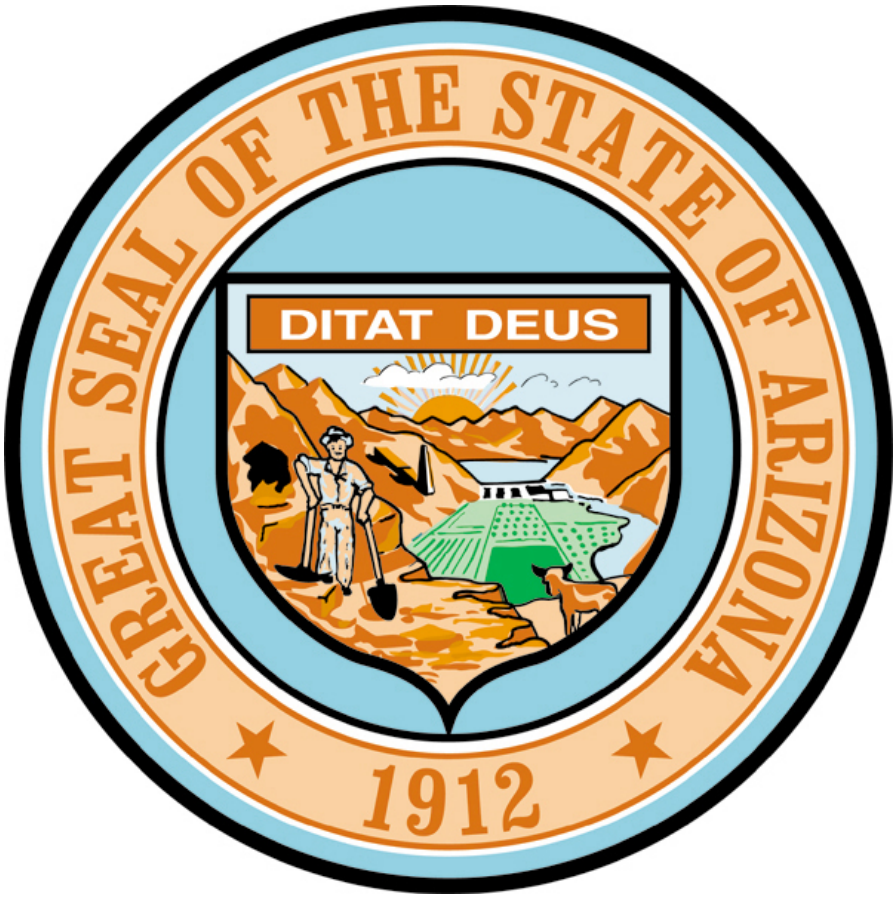

Emergency Medical Services Access Task Force Meeting

September 25, 2006

Emergency Medical Services Access Task Force

AGENDA

Amended 9/22/06

DATE	Monday September 25, 2006
TIME	1pm
LOCATION	Arizona Department of Health Services, 150 N. 18th Avenue, Suite 540-A Phoenix, Arizona 85007

I. CALL TO ORDER

II. TASK FORCE MEMBER ROLL CALL

A. Determination of quorum

III. WELCOME FROM THE CHAIR

A. Welcome and opening statement from the Chairman
B. Introductions
C. New Procedures for Ensuring Notice to Members
D. Review and acceptance of the June 7, 2006 minutes
E. Review and acceptance of the August 16, 2006 minutes

IV. DISCUSSION ITEMS

A. Presentation, Review and Discussion of findings and recommendations from task force members not previously submitted

B. Recruiting Physicians PowerPoint Presentation

C. Review and Discussion of Governor's Report Framework

i. Structure
ii. Needed data

D. Findings related to factors that may have lead to the current shortage of emergency department physicians

E. Recommendations for actions the State of Arizona can take to address the shortage of emergency department physicians

Emergency Medical Services Access Task Force

V. CALL TO THE PUBLIC

A public body may make an open call to the public during a public meeting, subject to reasonable time, place and manner restrictions, to allow individuals to address the public body on any issue within the jurisdiction of the public body. At the conclusion of an open call to the public, individual members of the public body may respond to criticism made by those who have addressed the public body, may ask staff to review a matter, or may ask that a matter be put on a future agenda. Members of the public body shall not discuss or take legal action on matters raised during an open call to the public unless the matters are properly noticed for discussion and legal action. A.R.S. § 38-431.01(G).

VI. SUMMARY OF CURRENT EVENTS

Members of the public body may present a brief summary of current events. Members of the public body shall not propose, discuss, deliberate, or take legal action on matters raised during a summary of current events unless the matters are properly noticed for discussion and legal action.

VII. ANNOUNCEMENT OF NEXT MEETING

The next scheduled meting is set for November 15, 2006 at 1:00 PM at the Arizona Department of Health Services located at 150 N. 18th Avenue, Phoenix, Arizona 85007, in Suite 540-A

VIII. ADJOURNMENT

Persons with a disability may request a reasonable accommodation, such as a sign language interpreter, by contacting Amanda Valenzuela, Program and Project Specialist, 602-364-3150; State TDD Number 1-800-367-8939; or Voice Relay Number 711. Requests should be made as early as possible to allow time to arrange accommodations.

Emergency Medical Services Access Task Force

Start Date	06-07-06	Anticipated End Date	01-01-07

Task Force Scope	• Identify Factors That May Have Lead To The Current Shortage Of Emergency Room Physicians. • Make Recommendations For Actions The State Of Arizona Can Take To Address The Shortage Of Emergency Room Physicians.

Task Force Mission	To Improve Emergency Department Care For Arizona Residents And Visitors.

Desired Outcomes	• Detailed Report To The Governor Recommending Actions To Improve Emergency Room Care • Implementation Timeline To Improve Emergency Room Care

Task Force Members				
Title	**Name**	**Other Phone**	**Work Phone**	**Email Address**
Chair	Chris Skelly			
Member	Linda Hunt			
Member	Paul Mullings			
Member	Bruce Bethancourt, MD			
Member	Charles Finch, DO			
Member	Donald Warne, MD			
Member	Thomas Ryan			
Member	Judith Berman			
Member	Mark Enriquez			
Member	Pat Rehn, RN			
Member	Richard Polheber			
Member	Jim Ledbetter			
Member	Roy Ryals			
Member	Julie Nelson			
Member	Dr. Art Pelberg			
Member	Susan Gerard			
Member	Tony Rodgers			
Member	Msgr. Richard O'Keeffe			
Member	Anne Winter			
Member	January Contreras			
Staff	Ron Anderson			

LEONARD, CLANCY & McGOVERN, P.C.
ATTORNEYS AT LAW
1700 NORTH SEVENTH STREET, SUITE 3
PHOENIX, ARIZONA 85006-2230

JAMES J. LEONARD, JR.
THOMAS P. McGOVERN
TYRONE MITCHELL
BRIAN T. LEONARD
AMY M. LEONARD

KENNETH P. CLANCY (-)

cpy Ron Anderson + file

August 17, 2006

Via Telefacsimile (602) 277-8844 and U.S. Mail

Chris Skelly, Chair
Emergency Medical Services Access Task Force
c/o SCOTT & SKELLY, L.L.C.
1313 E. Osborn Road
Suite 120
Phoenix, AZ 85014

Re: *August 17, 2006 1:00 p.m. meeting*

Dear Chris:

Yesterday, I contacted Ron Anderson to confirm the meeting place and time for today at 1:00 p.m. Mr. Anderson responded "We missed you at the meeting today." Needless to say, I was shocked and upset to find out that the meeting had been changed from August 17, 2006 to August 16, 2006. I had received absolutely no notification of any kind regarding this change. To understand how this happened, I would be interested to know when and how all other members of the Task Force were notified of the change of this meeting. If one looks at the posted minutes from the June 20th meeting, the minutes reflect an August 17th date.

I checked my old office and new office to see if any mail or email or voice mail had been left for me advising me of the change. No such luck. I acknowledge that some confusion may arise over my recent change in law firms (effective 8/1/06) However, on July 28, 2006, I sent a letter to the Task Force on my new letterhead advising of my new address, phone number and email. In addition, my old firm has been diligent and professional in getting me all correspondence.

I asked Ron Anderson if any others did not show yesterday. I believe he told me only 8 showed. (It is possible that he meant to say only 8 did *not* show.) If only 8 showed, then the Task Force did not have a quorum. Either way, there appears to have been a significant component of "no-shows" on a matter of state wide importance. I asked specifically about Msgr. O' Keefe, and Mr. Anderson responded: "He wasn't here today. I should make sure he is notified so that he doesn't come all the way up from Yuma tomorrow."

LEONARD, CLANCY & McGOVERN, P.C.
ATTORNEYS AT LAW

I also advised Ron that I had not received an agenda for the meeting. Ron emailed me a link to a 492 page .pdf file. It is unclear when this link was created. Again, I received no notice of this rather substantial document until after my call with Ron. There were significant documents that were not circulated sufficiently in advance to be meaningfully reviewed and digested prior to any meeting.

Appropriate communication seems to be a significant impediment here. I have some proposals for change and I ask that this letter be distributed to all board members and have this listed as an action item for the September 25th meeting:

1) Agendas should be mailed out at least two weeks in advance of any meeting.

2) Any documents to be distributed to the board, should be distributed at least one week before a scheduled meeting

3) A notice of upcoming meetings should be mailed out at least two weeks in advance of any meeting with the following options:

___ I will attend in person

___ I will attend by phone

___ I will be unable to attend

4) A schedule of upcoming meetings should be sent to the Arizona Capitol Times so that members of the public can be informed and attend if they so choose.

I have done a fair amount of research and inquiry into what are the problems facing patients and doctors in the intersection of the emergency rooms. My understanding was that we would come to this meeting (August 17) prepared to discuss these findings and to begin to discuss areas of concern. As a dutiful member of this task force I am concerned when a break down in communications occurs that precludes an open and honest exchange of ideas.

I am also concerned about the timing of the draft report on September 25, 2006. I certainly do not want to be the proverbial "stick-in-the-mud," but on the other hand, I feel as if we are proposing solutions for the sources of problems that have yet to be fully identified. The list that was identified in the .pdf was cursory. Perhaps it was discussed more fully in yesterday's meeting. Most of the research and inquiry I have done focuses upon the multiple root causes of the over-crowding occurring in Arizona's emergency

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ATTORNEYS AT LAW

rooms. How can we effectively perform our job, by proposing solutions to problems whose causes have not yet been fully identified, discussed and agreed to by our Task Force?

I apologize for sounding frustrated, but I do take this responsibility seriously. Please free to call me to discuss this more fully.

Very truly yours.

LEONARD, CLANCY & McGOVERN

Thomas M. Ryan

JAMES J. LEONARD, JR.
THOMAS P. McGOVERN
TYRONE MITCHELL
BRIAN T. LEONARD
AMY M. LEONARD

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KENNETH P. CLANCY (-)

copy Ron Anderson + file

August 17, 2006

Via Telefacsimile (602) 277-8844 and U.S. Mail

Chris Skelly, Chair
Emergency Medical Services Access Task Force
c/o SCOTT & SKELLY, L.L.C.
1313 E. Osborn Road
Suite 120
Phoenix, AZ 85014

Re: *August 17, 2006 1:00 p.m. meeting*

Dear Chris:

This afternoon I contacted Msgr. O' Keefe's office in Yuma, Arizona. I spoke specifically to his secretary, Bertha. Bertha advised me the Msgr. O' Keefe was on vacation this week. I asked Bertha if she or anyone on her staff received any notification of the change of the Task Force Meeting this week. Bertha looked on Msgr. O' Keefe's calendar and advised that she had not. I asked her to check Msgr. O' Keefe's e-mails to see if he may have received such notice by e-mail. Bertha went and spoke to another person who reviews Msgr. O' Keefe's e-mails and calendars matters. That person indicated to Bertha she did not recall receiving such an e-mail, and if she had she would have placed it on Msgr. O' Keefe's calendar, which she had not.

I would kindly ask that you pass this correspondence on to all Board members.

Very truly yours,

LEONARD, CLANCY & McGOVERN

Thomas M. Ryan

Emergency Medical Services Access Task Force
Meeting Minutes
June 7, 2006
1700 W. Washington, 8th Fl.
Phoenix, AZ

Members Present		Members Absent
Chris Skelly, Chairman	Mark Enriquez	Art Pelberg
Paul Mullings	Pat Rehn	
Bruce Bethancourt, MD	Richard Polheber	
Charles Finch (teleconference)	Jim Ledbetter	
Don Warne, MD	Roy Ryals	
Thomas Ryan	Susan Gerard	
Judith Berman	Tony Rodgers	
Msgr. Richard O'Keeffe	Anne Winter	

I. Call to Order

The Emergency Medical Services Access Task Force was called to order by Chairman Chris Skelly at 1:05 p.m. A quorum was present.

II. Task Force Member Roll Call

It was announced that task force member Charles Finch, was attending the meeting by teleconference.

III. Welcome from the Chair

A. Opening Statement from the Chairman

Chris Skelly introduced himself to the task force and thanked the task force members for agreeing to serve.

B. Welcome Comments from the Governor

Governor Janet Napolitano welcomed and thanked the task force for their attendance at the meeting. Governor Napolitano explained what she would like to see the task force accomplish which includes a written report with recommended actions and timelines for implementation in order to improve emergency and trauma care for Arizona residents and visitors.

Governor Napolitano stated that she created the task force to assess the status of Arizona's emergency room and trauma center physician supply, identify the factors that may have lead to the current shortage, and make recommendations for actions the State can pursue to address the situation.

Emergency Medical Services Access Task Force
Meeting Minutes
June 7, 2006
1700 W. Washington, 8th Fl.
Phoenix, AZ

IV. Task Force Member Introductions

Chairman Skelly asked each task force member to introduce themselves and give a brief summary of their background.

V. General Task Force Management Issues

A. Discussion of Open Meeting Law Requirements

Chairman Skelly announced that the task force was asked by the Governor to follow the Open Meeting Law and asked the task force members if they had any questions pertaining to the requirements or understanding of the Open Meeting Law. Ron Anderson advised the Task Force member that they each have a copy of the open meeting handbook in the materials provided. No questions were posed from the members.

Chairman Skelly reported that if any member had any questions concerning the Open Meeting Law to direct their question(s) to Ron Anderson at the Arizona Department of Health Services.

A question was posed as to whether a task force member could delegate someone to attend the meeting on their behalf.

It was reported that the Executive Order indicates that task force members may, with the permission of the Governor, send designees and that the designee would have full authority to vote on behalf of the member.

C. Discussion of Member Materials Availability Ten Days Prior

It was reported that in accordance to the Open Meeting Law, materials for the meeting will be available to the members ten days prior to the scheduled meeting date.

Chairman Skelly announced that members would receive their meeting materials via e-mail.

D. Discussion of Task Force Quorum Requirements

It was reported that the task force consists of 18 members, therefore, 10 members must be present in person or by telephone to constitute a quorum.

Emergency Medical Services Access Task Force
Meeting Minutes
June 7, 2006
1700 W. Washington, 8th Fl.
Phoenix, AZ

VI. Scope of the Task Force

A. Discussion of Task Force Mission

Task Force members were directed to the charter form in the materials provided to review the defined mission.

B. Discussion of Desired Deliverables

Discussion ensued concerning the various issues/problems facing Emergency Departments and Trauma Centers.

Issues/problems identified by the task force are as follows:

- Physician reimbursement
- Population growth
- Shortage of physicians in Arizona
- High number of uninsured individuals
- Rural communities access to health care services
- Physician shortage due in part to the high traffic of individuals accessing the ER
- Individuals accessing the ER instead of their primary care physician
- ER being accessed by individuals who could use other options for their healthcare needs- such as urgent care.
- Include nurse practitioners into the solution as a way to access primary care needs.
- Research other states with similar situations and see how their approach and/or policies can be applied to Arizona.

It was suggested that the task force identify and categorize the issues and decide which issues could be addressed by the task force in order to be more productive.

C. Discussion of Subcommittee Breakout Groups

It was suggested that instead of subcommittees the task force members be prepared to discuss and address their suggestions to the task force.

It was decided that members would e-mail to Ron Anderson who will disburse the information to the rest of the members, their top three suggested recommendations, in order of priority, for actions the State can take to address the shortage of physician supply in Arizona's emergency rooms and trauma centers (see paragraph 3 of Executive Order 2006-09).

The Chairman asked that recommendations be supported by data, studies, statistics, etc., to the fullest extent possible. The recommendation will be discussed at the next meeting and later prioritized. They will form the basis of the report to the Governor.

D. Discussion of the Anticipated Task Force End Date

Chairman Skelly announced December 13, 2006 as the last date scheduled for the task force to meet. It was reported that at the December 13th meeting the written report, including recommendations and timeline of implementation will be due and prepared for the Governor to review.

VII. Task Force Meeting Dates

A. Discussion of Tentative Meeting Dates

The task force was given dates of future scheduled meetings as follows:

- August 17, 2006
- September 25, 2006
- November 15, 2006
- December 13, 2006

B. Discussion of Meeting Locations

It was reported that the meetings are scheduled to begin at 1:00 p.m. and will be taking place at the Arizona Department of Health Services at 150 N. 18th Ave., Ste. 540-A.

Meeting was adjourned at 2:35 p.m.

Emergency Medical Services Access Task Force
Meeting Minutes
August 16, 2006
150 N. 18th Avenue, Suite 415-A
Phoenix, AZ

I. Call to Order

The Emergency Medical Services Access Task Force was called to order by Chairman Chris Skelly at 1:08 p.m.

II. Task Force Member Roll Call

Present:

Chris Skelly	Dr. Bruce Bethancourt	Judith Berman
Pat Rehn	Richard Polheber	Jim Ledbetter
Tony Rodgers	Anne Winter	January Contreras

Absent:

Paul Mullings advised he would not be able to attend
Dr. Charles Finch advised that he would send a representative
Ms. Susan Gerard advised that she would not be able to attend
Ms. Julie Nelson advised she would not be able to attend but Karen Owens will represent her at the meeting.

Failed to receive notice of the meeting date change:

Dr. Donald Warne	Mr. Tom Ryan	Mr. Mark Enriquez
Mr. Roy Ryals	Dr. Art Pelberg	

Msgr. Richard O'Keefe was on vacation out of the country

III. Welcome from the Chair

A. Welcome and opening statement from the Chairman

Chris Skelly welcomed everyone to the meeting and thanked the task force for submitting their recommendations.

B. Review and acceptance of the June 7, 2006

The meeting minutes of June 7, 2006 were approved as presented in the agenda packet.

IV. Member Presentations

A. Presentation of recommendations from Charles Finch, D.O. FACOEP Emergency Physician, Scottsdale Emergency Associates

Recommendation to the task force was to require Arizona hospitals to begin reporting metrics related to hospital and emergency room crowding, ambulance diversion, wait times, boarding patients in the emergency room, and other metrics related to the issue.

Secondly, the suggestion was made to continue to expand opportunities for nurse training and incentives for local Arizonans to choose a career in nursing.

B. Presentation of recommendations from Julie Nelson, Esq. Coppersmith, Gordon, Schermer, Owens & Nelson PLC- Presented by Karen Owens, Esq. on behalf of Julie Nelson

Karen Owens presented recommendations to the task force on behalf of Julie Nelson.

One recommendation Ms. Owens suggested was to increase funding for graduate medical education (GME) in order to increase the number of physicians in Arizona. This suggestion coincides with HB 2374 Health and Welfare Reconciliation Bill which helps provide additional reimbursement to hospitals to expand GME programs in order to embark on new programs.

Ms. Owens's second recommendation presented to the task force was to create a package of incentives for physicians who serve on call. The package would include incentives such as tax credits, "Rabbi Trusts", small business loan terms to physicians and tax incentives.

Ms. Owens' third recommendation was to reduce the need for on-call physician services. This recommendation would require managed care plans to provide on-call physicians to provide emergency and follow-up care services to insured patients, therefore insured patients would be not be "unassigned" patients for on-call purposes.

Discussion ensued concerning the proposed recommendations from Ms. Owens.

A comment was made indicating that the reimbursement rate in Arizona is significantly lower compared to other states which in turn creates difficulties for physicians to recruit partners as a result of low pay.

A suggestion was made to acquire accurate data for the percentage of physician residents who want to continue to practice in Arizona versus residents who want to practice outside of Arizona. It was reported that Arizona is at a 40% residency stay.

Ms. Owens proposed that the task force look into improving and/or creating a friendlier process for physicians to establish an office and practice in Arizona.

C. Presentation of recommendations from Judith Berman- Presented by Judith A. Berman, Esq.; Doyle, Berman, Gallenstein, P.C.

Judith Berman, Esq. presented her recommendations to the task force.

Ms. Berman reported that one of the issues/problems within the ED is the increase of patients with mental illness. After mentally ill patients have been evaluated, they wait in the ED for a psychiatric bed, of which there are an inadequate number available.

Ms. Berman recommended that the task force propose legislation geared to the increase of inpatient psychiatric bed capacity and establish specific temporary care centers for patients with mental illness.

Discussion ensued regarding the issue of mentally ill patients in the ED. It was reported that while mentally ill patients are waiting for a bed, they require one-on-one monitoring which impacts the flow of patients throughout the ED.

Additionally, the task force discussed the difficulty of funding for mentally ill patients and reported that some insurance providers will only cover a minimum of the expenses for the patient. The entire issue was described as a cyclical aspect of the problem.

The discussion further evolved into asking what the Arizona Department of Health (ADHS) is doing to assist the ED with mentally ill patients. It was suggested that this question be addressed to Susan Gerard, Director of ADHS.

It was reported that patients trying to be admitted into the hospital go through the ED versus waiting the allotted time they are given by the hospital. In turn, this creates a queue in the ED. However, it was reported that this issue is an internal fix and should be corrected.

Ms. Berman's second recommendation was to promote emergency physician access to computerized medical records. In doing so, this would provide physicians with the medical history of patients they are treating and create a reduction in expenditure of time and resources in the ED.

D. Presentation of recommendations from Pat Rehn, RN, MS, Executive Director- Arizona Nurses Association

Pat Rehn presented two recommendations to the task force. Ms Rehn's first recommendation was to utilize nurse practitioners as an access to primary care needs.

Ms. Rehn reported that nurse practitioners are licensed by Arizona to provide primary and acute care health services. It was suggested that the task force create ways to remove the current barriers for nurse practitioners and allow them to practice alone and not along side a physician.

Ms. Rehn reported that accessing nurse practitioners for primary and acute care would assist in reducing emergency room use.

Ms. Rehn's second recommendation to the task force was to continue to support the ongoing efforts to increase faculty in nursing programs. However, it was reported that further efforts need to address competitive salaries for faculty since Arizona salaries are far below the salaries in hospitals and other practice settings.

E. Presentation of recommendations from Susan Gerard, Director, Arizona Department of Health Services

Susan Gerard was not present at the meeting to present her recommendations, which had been submitted to the task force before the meeting.

F. Presentation of recommendations from Tony Rodgers, Director, AZAHCCCS

Tony Rodgers suggested to the task force that GME funds be increased and utilized to create programs to support residents on how to prepare for a practice as well as business management. With such programs established it will increase the number of resident physicians to stay and practice in Arizona.

G. Presentation of recommendations from other task force members not previously submitted

Richard Polheber presented his recommendations to the task force. Mr. Polheber reported to the task force that there are two key principles dealing with the situation at hand, which are 1) overcrowding of patients in the emergency rooms, and 2) shortage of physicians, both primary and specialty.

Mr. Polheber suggested three categories for the task force to consider as a recommendation.

1. Medical Liability
   Create a "protection" for physicians who treat patients in the emergency room. This reform could require patients to sign a wavier that would require any resolution of issues to be settled by a state wide compensation panel, which would be funded by the state. The panel's role would be to set compensation recovery limits in cases of unanticipated injuries.

2. Annual income earning for physicians
   Create a tax incentive for physicians who establish themselves in Arizona and practice for a specific number of years. This model could also be used with specialty physicians.

   In order for the tax incentive to be a success it would have to be sufficiently large in order to motivate physicians to come and practice in Arizona.

3. Reduce emergency room visits
   Expand the number of federally funded health centers throughout the state.

A comment was made by a task force member indicating that there are retired medical professionals who would like to practice, however the cost for liability insurance is too high. The retired medical professional population could assist in seeing patients part time, but are discouraged with the high cost of liability coverage. Various ways to bring them into the rates of specialty coverage physicians or reduce their premiums was discussed.

V. Discussion Items

It was reported that from the recommendations presented and submitted to the task force a report would be drafted for the next meeting.

VI. Call to the public

A representative from the Arizona Medical Association addressed the task force. He commented that the situation at hand is very complicated and difficult to resolve. However, he suggested to the task force that it have someone with premium knowledge at the table when dealing with liability costs and procedures.

VII. Summary of Current Events

No report given.

VIII. Announcement of next meeting

The next meeting is scheduled for September 25, 2006.

IX. Adjournment

Meeting adjourned at 3:00 p.m.

EMERGENCY MEDICAL SERVICES ACCESS TASK FORCE

FROM: THOMAS M. RYAN, ESQ.
TO: CHRIS SKELLY, CHAIR/ TASK FORCE MEMBERS
RE: ACEP NATIONAL REPORT CARD: ANALYSIS, PROBLEMS & SOLUTIONS
DATE: 9/25/06

I. ACEP'S NATIONAL REPORT CARD ON THE STATE OF EMERGENCY MEDICINE: QUESTIONS REGARDING DATA, METHODOLOGY & ASSUMPTIONS

A. Overview

Why are we assembled here as a Task Force studying the state of emergency services in Arizona? This is an important question. The answer stems from a National Report Card issued earlier this year by a respected group of physicians which gave the State of Arizona a near-failing grade (D+). There appears to be an assumption that the National Report Card has accurately assessed our situation, and provides us with a map to provide acceptable emergency medical services. There are significant questions regarding this assumption.

On January 10, 2006, the American College of Emergency Physicians (ACEP) issued "The National Report Card on the State of Emergency Medicine." In ACEP's press release accompanying the Report Card, it stated that the U.S. "... finds an emergency system characterized by overcrowding, declining access to care, soaring liability costs and a poor capacity to deal with public health or terrorist disasters." See "Eighty Percent of Country Earned Mediocre or Near-Failing Grades in First-Ever 'Report Card' on State of Emergency Medicine," ACEP press release, January 10, 2006.

According to the ACEP press release, these grades were determined by an "objective panel of emergency medical experts" assembled by ACEP. This panel "used a range of available data to develop 50 measures for grading each state on a scale of A to F for its support in four areas: Access to Emergency care; Quality of Care and Patient Safety; Public Health and Injury Prevention; and Medical Liability Environment." See ACEP press release, January 10, 2006.

ACEP's stated purpose for this Report Card was to provide "...local, state and federal officials with information to identify their states' strengths and areas

for improvement, while allowing them to make comparisons and learn from other states." See ACEP press release, January 10, 2006.

The Report Card concludes with a state-by-state analysis giving each state a grade for each of the four categories described above, and then an overall grade. ACEP admits that no state got an "A" while no state got an "F" either. As indicated above, Arizona received a grade of D+.

While the stated purpose of the Report Card was salutary, ACEP's Report Card falls short of its goal. The following analysis shows why.

B. The Task Force Composition

With the sole exception of the Executive Director of ACEP (who is a J.D.) all of the members of the Report Card Task Force were board certified emergency room physicians. Accordingly, the Report Card Task Force suffers from "reviewers' bias," a well-recognized research phenomenon that can lead to logic fallacies in the design, methodology and ultimate conclusion of a study. One might ask: "Who better to study the problem of declining access to emergency medical services than emergency room doctors?" This is not an insignificant question. The answer (and the problem) is that the causes of the problems are multi-factoral. Accordingly, there were significant components to the delivery and receipt of emergency medical services that were left off of the Task Force.

For example, there is no indication that anyone from other specialties (*i.e.,* neurosurgery, burn trauma, hand surgery, plastics, cardiology, general surgery, radiology, psychiatry and so forth) were involved or even invited. This is a significant flaw. Lack of access to specialty care in the hospital setting is one of the most important factors complicating patient flow in and out of the emergency department is. The failure to include other specialties leads to significant deficiencies. For example, the Report Card states about Arizona:

> The number one problem for Arizona emergency departments is too few specialists on call. A recent Johns Hopkins study found that 94 percent - the highest percent in the nation- of Arizona emergency medical directors reported inadequate on-call specialist coverage, compared with 63 percent nationwide. More than half of the state's emergency departments have unmet needs for neurogsurgeons; hand surgeons; vascular surgeons; plastic surgeons; ear, nose and throat specialists; and gastroenterologists.

See ACEP National Report Card 2006, at page 23. In spite of recognizing this as an issue, this problem did not make it into the list of 50 questions to be analyzed by ACEP[1]. In point of fact, the Report Card never studied or analyzed the impact that the lack of access to specialty care has on emergency services.

This has spill over into other areas of the Report Card. For example, by all estimation the United States is facing a booming geriatric population, yet there was no consideration given to that in the "Public Health & Injury Prevention" category. Similarly, the United States is facing a significant crisis with obesity, and early onset Adult Type II Diabetes, and all of their related medical crises. Yet, again, there was no consideration given to these problems anywhere in the Report Card.

It is unclear, whether any of the Report Card Task Force Members were actively involved in Level I trauma care, but probably unlikely, as little attention is paid to that very important issue.

The Report Card Task Force apparently had no members associated with hospital administration. In order to understand patient access and patient flow, questions should have been asked, it is important to know what the hospitals

[1] ACEP erroneously points to this fact as evidence of a "decreasing supply of physicians in the state [of Arizona]." First, this is contrary to what the AMA stated in Smart, Derek, Physician Characteristics and Distribution in the US (2006 Ed.) at page 309 which notes that since 1975 *every state* increased its physician to population ratios. Second, what ACEP fails to acknowledge is that Arizona has had an explosive population growth since World War II, and a state legislature that has been reluctant to fund a new medical school. Third, the problem is not a shortage of ED physicians, but a shortage of specialist physicians to whom the ED physicians can send the patients to once they have been stabilized. Indeed, the Emergency Physician group, as a whole, has grown 489% since 1980 according to the AMA. See, Physician Characteristics and Distribution in the US, *id.* at page 312, Table 5.2.

know about the issue. As the Report Card Task Force pointed out:

> The number of people coming to emergency departments continues to increase, with nearly 114 million patient visits in 2003, the highest number ever, according to the Center for Disease Control and Prevention (CDC). ***At the same time, the overall capacity of the nation's emergency systems has decreased, with hundreds of emergency departments closing in the past 10 years. The number of emergency departments has decreased by 14 percent since 1993, according to the CDC, and hospitals are operating far fewer beds than they did a decade ago. <u>During the 1990's, hospitals lost 103,000 staffed inpatient medical-surgical beds and 7,800 intensive care unit beds nationwide</u>.*** (Emphasis added.)

See National Report Card, "Facts Behind the National Grade," p.2. There is a very significant question as to why this trend developed, and whether hospitals see a need or have a plan to reverse this trend. As will be seen later, this drastic reduction in staffed medical-surgical beds, and ICU beds, is a significant contributor to the problem of reduced access to emergency medical services. One CFO of a suburban hospital indicated to me in a telephone interview that for his hospital:

- For every 100 ER admits, 15 - 25 need to be admitted to a staffed hospital bed (National average = 13 - 14%)
- This hospital had 60,000 ER admits last year with approximately 12,000 admits to staffed hospital beds
- For this hospital 6 out of every 10 admissions to staffed hospital beds for 2005 came from the ED, while 2 out of every 10 admissions came from elective surgery, and 2 out of every 10 admissions were for labor & delivery
- Currently, it takes approximately 4 years from the application process to opening the doors for a staffed hospital bed, and the cost to apply, design, build and equip one hospital bed is approximately $1,000,000
- The East Valley is currently 900 staffed hospital beds *short* of what it needs to service the East Valley population

- It will take $900,000,000 to bring a sufficient number of staffed hospital beds on-line to meet the East Valley's needs

Yet there is no analysis or help given to us by the Report Card Task Force on this significant question. By way of illustration, the Task Force analyzed only *one* question on the issue of access to hospital beds, and did not even bother to distinguish between medical-surgical beds and ICU beds. It did not ask any questions about the impact of "for profit" hospital systems vis-a-vis "not-for-profit" hospital systems. It did not evaluate the impact of the merger mania and "consolidation" (read that to clearly mean hospital closures) that has swept our country for the last twenty years.

The Report Card Task Force apparently had no members associated with anyone from either a federal or private insurance/reimbursement industry. This is a significant flaw. If we are to improve patient access to quality medical services, we need to know how will such changes be financed, and whether such capital can be provided. We need to know if there are trade-offs from other medical services. We need to know the cost-benefit ratio of making these changes.

The Report Card Task Force apparently had no member that represented the general patient population. Accordingly, the question of patient safety and patient outcomes is given short shrift in this study. By way of illustration, there were no questions regarding patient recidivism because of missed diagnoses, medication errors, and/or medical negligence. There were not even any questions on avoiding medical errors in the first instance. There was no attempt to investigate and evaluate patients' attitudes, concerns and choices as they relate to the use of the emergency room.

In summary, the Report Card Task Force was limited by having only ACEP at the table and by not inviting other interested and knowledgeable parties to the table. As a result, many of the questions that should have been asked and evaluated were not.

C. Lack of Empirical Proceess & Analysis

The preamble to the ACEP Task Force Report Card identifies the 50 areas it inquired into. Yet, the Task Force did not identify or describe the process by which it arrived at these questions. This failure leads to seemingly anomalous results. By way of illustration, there are twelve questions on tort reform (four questions alone on the question of caps on "non-economic" damages) and only

one question of Level I Trauma service. This is problematic, especially for a state like Arizona where the Report Card Task Force recognizes "Trauma centers are a critical need for the state [of Arizona]." See ACEP National Report Card 2006 at page 24. This creates a statistical bias in favor of tort reform and against developing more Level I Trauma Centers. As will be seen later, this makes no sense in light of the fact that Arizona has been enacting substantial tort reform - especially in the arena of medical negligence claims - for more than thirty years, and where the Arizona Superior Court has been seeing significant declines in the raw numbers as well as the percentages of medical cases filed.

The preamble to the ACEP Task Force Report Card also identified the percent of weight it gave each question in each of the four main categories, but again did not ever explain how it arrived at the weighting and why such weighting would have been empirically appropriate. For example, the category "Medical Liability Environment" is weighted 25%, without any explanation as to why. There is no empirical correlation established that eliminating an injured person's right to compensation when injured by fault of a health care provider, improves patient access or the quality of care given. In fact, the ACEP Report Card proves just the opposite.

Public Citizen, a non-profit think tank, analyzed the ACEP Report Card and found:

· The top states for access to emergency care were all at the bottom of the heap in terms of ACEP's medical liability environment scale. Not one of them has a hard $250,000 cap on non-economic damages.

	Access to Care	Liability Environment
District of Columbia	A+	F
Pennsylvania	A	F
Massachusetts	A	D-
Maine	A	D
Rhode Island	A	F
Ohio	A-	D
Connecticut	A-	F

· By contrast, the states that earned the highest marks on ACEP's medical liability environment scale received significantly lower grades for access to care.

	Access to Care	Liability Environment

Texas	D+	A+	
California	C	A+	
Montana	C+	A-	
Nevada	D+	A-	
South Carolina	C	B+	
Georgia	D+	B-	
Colorado	C+	B-	

. Significantly, most states with failing grades on ACEP's liability environment scale received average-to-high scores in the "quality and patient safety" category. This tends to support the contention of patient advocates that removing the threat of full legal accountability may result in poorer care and more dangerous

environment for patients.

	Access to Care	Liability Environment
New Jersey	A+	F
Connecticut	A+	F
District of Columbia	A-	F
Pennsylvania	A-	F
Maryland	B+	F
Rhode Island	B+	F
North Carolina	C	F
Vermont	C	F
Tennessee	C	F

This last category, truly skewers the results in favor of medical liability tort reform. By way of example, New Jersey scores A+ for "Quality and Patient Safety" and B+ for "Public Health & Injury Prevention", yet it scores F for "Medical Liability Environment" thus pulling its overall grade down to just a C+. Why? Conversely, Texas scores D+ in "Access to Emergency Care," D+ in "Quality and Patient Safety," D in "Public Health & Injury Prevention," yet its score of A+ in "Medical Liability Environment" pulls its overall grade up to a C. Why?

One would think that the best indicator of "Medical Liability Environment" would be the relative increase or decrease year over year in the cost of medical liability insurance rates on a state-by-state basis. Not if you are ACEP. By way of comparison, look at how ACEP evaluates this important issue:

State	% Increase in Premiums[2]	Caps	Medical Liability Grade
Arizona	76.58%	No	D-
Montana	83.67%	Yes	A-
So Carolina	120.94%	Yes	B+

Aside from the fact that this helps establish that caps on non-economic damages do not help reduce medical malpractice premiums, it simply makes no sense why ACEP decided to weight the existence of caps much more significantly than the

[2] From the category entitled "Increase in physicians' medical liability insurance rates (2001-2004):"

relative increase in what doctors are being charged year over year by the insurance companies that sell the insurance.

Another category that defies logic in the way that it was scored by ACEP is "Access to Emergency Care." By way of illustration, Alabama and Arizona each were scored "D+" in this category by ACEP. The number of annual ED visits per board certified emergency room physician, the number of board-certified emergency room physicians per 100,000, and access to Level I Trauma centers would seem to be the three key indicators of access to emergency care. Here is the comparison for Alabama and Arizona:

Alabama:

- Annual ED visits per ED physician: 14,402
- ED physicians/ 100,000 people: 3.29
- Trauma Centers/1,000,000 people: 0.44

Arizona:

- Annual ED visits per ED physician: 4,335
- ED physicians/ 100,000 people: 7.16
- Trauma Centers/1,000,000 people: 1.05

Alabama's ED doctors have to do more than 300% more ED patient visits than their counterparts in Arizona. Arizona has 200% more ED physicians per 100,000 people than does Alabama. And Arizona has more than 236% greater access to a Level I Trauma Center for its citizens than does Alabama. Yet, both states receive the same D+ grade.

Using the same parameters let's compare Arizona with Indiana, a state which ACEP gave a higher grade to for "Access to Medical Care."

Indiana:

- Annual ED visits per ED physician: 6,491
- ED physicians/ 100,000 people: 6.16
- Trauma Centers/1,000,000 people: 0.48

Arizona:

- Annual ED visits per ED physician: 4,335

- ED physicians/ 100,000 people: 7.16
- Trauma Centers/1,000,000 people: 1.05

Again, Arizona beats Indiana in these key categories, yet still gets a worse grade from ACEP (D+) for Access to Emergency Care than does Indiana (C+).

II WHAT IS NOT CAUSING THE OVERCROWDING

A. Medical Malpractice Litigation In Arizona

One of the issues that is a recurrent theme in discussions such as these, is a perceived need to limit and reduce and injured patient's right to seek recourse. Since 1975 Arizona has been enacting limitations on the right of patient recovery in medical negligence actions. It has:

- Changed the "collateral source" rule to allow the admission of evidence of workers compensation, health insurance, life insurance and so forth, against the injured party at the time of trial

- Abolished joint and several liability and adopted pure comparative fault

- Adopted Medical Liability Review panels (but later rescinded that, in part, by request of the medical liability carriers)

- Limited injured patients to one standard of care expert witness, while allowing the defendant health care provider two

- Adopted a rule requiring Affidavits of Merit anytime a health care provider is named as a party at fault

- Removed doctors who abuse or neglect vulnerable adults in the hospital setting from the ambit of the Adult Protective Services Act, and shortened the statute of limitations for the Act from 7 years to 2 years

Because of these changes, the number of medical malpractice filings in all counties of the Arizona Superior Court have been declining, both as a raw number and as a percentage of the total number of civil cases filed. Some counties have gone more than two years without any medical malpractice cases being filed at all. And contrary to popular belief, Arizona's rural counties have far

and away, fewer medical malpractice cases filed in their Superior Courts, giving lie to the common belief that medical negligence claims are chasing doctors away from the rural areas of Arizona.

Apache County[3]

Fiscal Year	Med Mal Filings	Total Civ Filings	% Tot Civ Cases
1999-2000	0	146	0.00
2000-2001	0	154	0.00
2001-2002	0	117	0.00
2002-2003	2	170	2.30
2003-2004	0	194	0.00
2004-2005	0	202	0.00

Cochise County

Fiscal Year	Med Mal Filings	Total Civ Filings	% Tot Civ Cases
1999-2000	15	602	2.50
2000-2001	8	650	1.20
2001-2002	7	626	1.10
2002-2003	8	754	1.00
2003-2004	3	844	0.03
2004-2005	3	828	0.03

Coconino County

Fiscal Year	Med Mal Filings	Total Civ Filings	% Tot Civ Cases

[3] Taken from the Arizona Supreme Court's Annual Reports on the state of the court system in Arizona at http://www.supreme.state.az.us/stats Data Reports for FY 1999 - 2005.

1999-2000	9	618	1.50
2000-2001	10	695	1.40
2001-2002	9	650	1.40
2002-2003	5	701	0.70
2003-2004	5	734	0.10
2004-2005	7	717	0.90

Gila County

Fiscal Year	Med Mal Filings	Total Civ Filings	% Tot Civ Cases
1999-2000	4	281	1.40
2000-2001	4	218	1.80
2001-2002	6	296	2.00
2002-2003	5	310	1.60
2003-2004	4	323	1.20
2004-2005	6	337	1.80

Graham County

Fiscal Year	Med Mal Filings	Total Civ Filings	% Tot Civ Cases
1999-2000	2	126	1.60
2000-2001	3	133	2.20
2001-2002	4	141	2.80
2002-2003	1	157	0.60
2003-2004	1	168	0.60
2004-2005	1	143	0.70

Greenlee County

Fiscal Year	Med Mal Filings	Total Civ Filings	% Tot Civ Cases
1999-2000	0	33	0.00
2000-2001	1	25	4.00
2001-2002	0	18	0.00
2002-2003	1	34	2.90
2003-2004	1	35	2.90
2004-2005	0	37	0.00

La Paz County

Fiscal Year	Med Mal Filings	Total Civ Filings	% Tot Civ Cases
1999-2000	0	145	0.00
2000-2001	1	125	0.80
2001-2002	0	110	0.00
2002-2003	0	239	0.00
2003-2004	2	155	1.30
2004-2005	1	159	0.60

Maricopa County

Fiscal Year	Med Mal Filings	Total Civ Filings	% Tot Civ Cases
1999-2000	391	31,262	1.25
2000-2001	446	28,005	1.60
2001-2002	460	31,123	1.50
2002-2003	507	34,860	1.45

2003-2004	449	36,164	1.20
2004-2005	446	36,013	1.20

Mohave County

Fiscal Year	Med Mal Filings	Total Civ Filings	% Tot Civ Cases
1999-2000	9	932	0.90
2000-2001	9	1024	0.90
2001-2002	14	866	1.60
2002-2003	14	909	1.50
2003-2004	12	869	1.40
2004-2005	12	1124	1.00

Navajo County

Fiscal Year	Med Mal Filings	Total Civ Filings	% Tot Civ Cases
1999-2000	7	412	1.70
2000-2001	6	445	1.40
2001-2002	7	352	2.00
2002-2003	3	324	0.90
2003-2004	6	373	1.60
2004-2005	2	371	0.50

Pima County

Fiscal Year	Med Mal Filings	Total Civ Filings	% Tot Civ Cases
1999-2000	144	6749	2.10

2000-2001	132	6039	2.20
2001-2002	136	6172	2.20
2002-2003	93	6929	1.30
2003-2004	80	6963	1.20
2004-2005	110	7204	1.50
2005-2006[4]	67	7063	0.95

Pinal County

Fiscal Year	Med Mal Filings	Total Civ Filings	% Tot Civ Cases
1999-2000	4	1140	0.35
2000-2001	3	1090	0.27
2001-2002	10	1255	0.79
2002-2003	8	1363	0.59
2003-2004	8	1465	0.55
2004-2005	8	1653	0.48

Santa Cruz County

Fiscal Year	Med Mal Filings	Total Civ Filings	% Tot Civ Cases
1999-2000	0	368	0.00
2000-2001	0	367	0.00
2001-2002	0	448	0.00
2002-2003	0	500	0.00
2003-2004	1	478	0.21

[4] From information given by the Pima County Statistician.

2004-2005	0	514	0.00

Yavapai County

Fiscal Year	Med Mal Filings	Total Civ Filings	% Tot Civ Cases
1999-2000	10	1194	0.84
2000-2001	10	1160	0.86
2001-2002	26	1174	2.21
2002-2003	16	1354	1.18
2003-2004	16	1404	1.14
2004-2005	10	1425	0.70

Yuma County

Fiscal Year	Med Mal Filings	Total Civ Filings	% Tot Civ Cases
1999-2000	2	836	0.24
2000-2001	5	814	0.60
2001-2002	6	860	0.70
2002-2003	5	976	0.50
2003-2004	3	1027	0.29
2004-2005	6	1081	0.55

The plain fact of the matter is that most of these medical malpractice filings are settled short of trial. By way of example, in Maricopa County, over the last five years, there have been only 135 medical malpractice trials, resulting in only 25 plaintiff verdicts and 110 defense verdicts[5]. In short, only 5.8% (135/2308) of

[5] This is from private correspondence with the Hon. Ana Baca, Presiding Civil Judge of the Maricopa County Superior Court.

all medical malpractice cases filed in Maricopa County for the last five years have ended up in trial.

B. Patients with minor ailments:

A recent study reported in the Annals of Emergency Medicine (8/23/06) reported that people who jam emergency rooms with sore throats, backaches and other minor conditions do not cause overcrowding in ER's, contrary to conventional wisdom. The study found that each emergency room patient with a minor ailment increase the overall stay for patients with true emergencies by 32 seconds and the treatment time by 13 seconds. The study found that the major causes of the overcrowding were lack of staffed inpatient beds and lack of on-call specialists. One of the authors of the study noted that in the United States, that U.S. hospitals lost over 100,000 inpatient beds in the 1990's as administrators cut costs. This study was conducted by examining the records of 4.1 million patients in 110 ER's in Canada.

II PROBLEMS & SOLUTIONS

A. Immediate ways to ease overcrowding:

In light of the fact that statistically, only 15 - 20% of all admittees to an ED in Arizona, are admitted to a hospital bed, that could suggest that as many as 80 - 85% of all ED patient visits can and should be dealt with in other ways or in other venues. Here are some considerations:

- **Public Education campaign**: There should be a statewide effort to educate people about the appropriate use of an ED, and to educate them about alternatives. For example, many HMO plans do have a health hotline. Patients should be encouraged to use an Urgent Care facility. Patients should be encouraged to recognize the symptoms of the most serious problems (heart attack for example) and get to and ED in that situation.

- **Development of an Urgent Care system:** In Texas, some hospital districts are opening up Urgent Care (UC) facilities, right next to the hospitals. Arizona should look at what other states are doing to develop and encourage the use of adjunct UC's. This Task Force should also take a look at the Gilbert Emergency Hospital created and designed by Timothy Johns,

M..D. This hospital has kept wait times to less than 30 minutes per patient, and is now looking to grow.

- **Financial Resources:** The Arizona Daily Star reported yesterday, that less than $47 million of a $1 billion fund created by Congress to pay for the indigent care of illegal immigrants has been paid out. Arizona stands in line to receive a fairly significant sum, but the hospitals seem either frustrated or unsure of how to file for the reimbursement. Arizona should look at ways to make sure those who are eligible for AHCCCS are receiving it, so that those Arizonans will be more inclined to seek out the help of a doctor they are familiar with, rather than the ED doctor.

B. Longer Term Solutions:

- **Development of Staffed Hospital Beds**:
  Since this seems to be one of the largest drivers of boarding patients in the hallways, this will take some creativity and a lot of capital. We should look at ways to streamline the approval process for the development of additional hospital beds. This will be much more of a challenge in Arizona's rural communities where access to capital is not sufficient.

- **Development of On-Call Specialists:**
  The American College of Surgeons has a list of recommendations that should be examined for possible solutions. Uncompensated work for on-call specialists is one of the big drivers. Requiring hospitals to provide stipends "per piece work" (i.e., per surgical case) or on a monthly, or weekend basis, to physician groups may be one way to deal with this issue. Liability concerns for taking on cases of "unassigned patients" (i.e., not patients who come through the doctor's office) were also expressed. Creating a state-sponsored fund to (1) pay the additional insurance premium or (2) provide additional coverage, for on-call specialists who treat unassigned patients, should be considered.

- **Recruitment of Nurses and other medical support staff:**
  Arizona should continue its commitment to the development of

the Downtown Medical School, and accelerate it if possible. Currently, many of Arizona's hospital systems are recruiting nurses from foreign countries to fill the gap that currently exists. A study should be undertaken to determine if current pay for Nurses and other medical support staff is effective.

Recommendations to: The Emergency Medical Services Access Task Force

Submitted by: Roy L. Ryals C.E.P.
Director of Emergency Medical Services
Rural/Metro - Southwest Ambulance

It is clear from all of the discussion at the Task Force meetings and the various research data that has been provided to the Task Force members, Arizona is experiencing a shortage of Specialty Physician coverage and in some instances Emergency Physician coverage in both metropolitan and rural hospitals in the State. Even though physician coverage is not particularly an expertise of this Task Force member, the nature of the discussion and the consistency of the message cannot be misinterpreted. The practice environment in Arizona does not facilitate and support the recruitment and retention of Specialty Physicians willing to practice in the Emergency Department. While the reasons are multi-factorial, the bottom line has always been and continues to be that the financial incentives to practice are less attractive in this State. This, combined with the adverse litigation environment in providing Emergency Department coverage, makes this State less attractive to practice in than in others, resulting in the shortages experienced in Arizona.

The below listed recommendations are true to the charge of this Task Force, relating to changes that are possible at the State level. They, in no way attempt to address issues that are inherently Federal such as declining Medicare reimbursement.

TORT REFORM

Treatment by Specialty Physicians in the emergency setting is episodic and complaint related. There is little, if any, physician / patient relationship prior to the event and no opportunity for the patient to develop a level of trust in the physician's skills and ability prior to treatment. Non-scheduled procedures necessitated by the emergency patient frequently have less than optimal outcomes than those experienced in elective events. Accordingly, the likelihood of litigation is at it's highest in the emergency setting. Arizona's medical liability environment must take this eventuality into consideration by:

Raise the standard of proof for legal liability to the "Clear and Convincing" level of proof from the preponderance of the evidence level. (It should be noted that pre-hospital providers of care have the standard set by state law as being "Gross Negligence," which recognizes the inherent difficulty in providing care in the emergency setting.)

Place limits on non-economic damages for patients treated in the emergency setting. This keeps in place the reasonable expenses incurred as actual damages while at the same time provides some protection to the practitioner from

emotional verdicts that can cripple an individual or insurance carrier based upon the perception of a run away jury.

Arizona has made an important step in the adoption of more stringent requirements for expert witnesses to insure that medical practitioners testifying against another are qualified to render opinions that are well founded with the realities of the practice environment of the case at hand. Arizona should **take additional steps to streamline the judicial environment** to require the limitation of duplicative discovery, depositions and expert witness usage. This will reduce the cost of defense of frivolous and unfounded litigation by attorneys that make a living on settling cases based on the known reluctance of the defendant (or the defendant's insurance carrier) to incur litigation expense.

REIMBURSEMENT

Trauma, in large part, is a disease of the uninsured and under insured population. The treatment of trauma requires the services of Specialty Physician coverage across a broader range than any other disease entity. The lack of hand surgeon, plastic surgeon, orthopedic surgeon, EENT, pediatric and neurosurgery capability have hampered the ability of even the largest Trauma Centers in Arizona in being able to accept trauma patients. Much of the reluctance of Specialty Physician coverage is the lack of adequate reimbursement for services provided. Potential State actions to mitigate this problem include:

Provide AHCCCS coverage, retrospectively, for patients that enter the hospital through the Emergency Department, require Specialty treatment (surgery as an example) and then are determined to be AHCCCS eligible at a later date. Currently hospitals can be reimbursed by AHCCS from the date of admission, but physicians that provide the treatment are not.

Adjust the poverty level threshold for AHCCCS eligibility to cover more of the so-called "Working Poor" or "Notch Group."

Provide financial incentives to Specialty Physicians that provide Emergency Department coverage by increased reimbursement by the State for treating patients in the emergency setting.

Consider the development of "Specialty Physician Pools." In conjunction with hospitals, develop a public/private consortium to credential and coordinate a pool of Specialty Physicians to provide coverage for all participating hospitals in a given community. This pool would be funded by both the State and individual participating hospitals, to provide compensation to Specialty Physicians willing to provide coverage and at the same time reduce the duplicative processes necessitated by current coverage plans, where each hospital is competing with every other hospital for coverage. An additional benefit of

such a consortium would be the potential to reengage those Specialty Physicians that have limited their practices to outpatient clinics and specialty hospitals thereby avoiding Emergency Department coverage requirements.

SPECIALTY TRIAGE

Lastly, while not specifically a charge of this Task Force, I cannot let down my EMS brothers and sisters by failing to make the following recommendation.

> **The lack of Specialty Physician coverage should not drive triage decisions made in the field on patient destination**. Every general emergency department must accept all emergency patients and make arrangements for either Specialty Physician coverage or appropriate secondary transport to that coverage if necessary.

There is a trend in the pre-hospital environment to place an ever-increasing burden on Emergency Medical Technicians and Paramedics to, in essence, diagnose the patient's malady in order to determine the appropriate destination hospital. This in large part is being driven by the lack of certain Specialty Physician Coverage's on any given day at any given time at any given hospital. While the triage of major trauma to a Level 1 Trauma Center, stroke patients to Stroke Centers, and pediatric patients to pediatric capable facilities is not only appropriate but also doable, the field determination if the "bad headache" is a neurosurgical emergency or if the sprained ankle is actually a fracture, is not. Placing the burden of diagnosis on the EMS provider to determine destination based upon a hospital's current coverage level is not only impractical, it is dangerous. Accordingly, any hospital licensed to provide general emergency department services should be capable and willing to accept all emergency patients that are not appropriately triaged to other facilities where there are defined levels of competency and clear cut triage guidelines.

Respectfully submitted:

Roy L Ryals C.E.P.

RECRUITING ARIZONA PHYSICIANS
9-21-06

Issue:

How can Arizona expand the number of primary care and specialist physicians practicing in rural and medically underserved areas to reduce the burden on emergency medical service providers?

Background:

The *Arizona Physician Workforce Study* found that

- The national average physician to population ratio is 283 physicians per 100,000.
- Arizona's physician to population ratio is 207/100,000, ranging from a high of 276/100,000 in Pima County to a low of 48/100,000 in Apache County.
- Low medical school enrollment and lack of growth in residency positions in Arizona will continue to limit the number of practicing physicians that can be obtained from Arizona medical schools and residency programs

Other studies have shown that approximately 45-50% of medical residents leave Arizona to practice elsewhere.

Establishing any successful medical practice requires a substantial investment of time and resources. Few people completing a residency have the means to start a practice from the ground up.

In addition, an AHCCCS-sponsored study of rural health care providers found that recruitment of providers in rural areas was difficult because of

- Professional isolation, with limited technical support and equipment.
- Professional demands placed on rural providers, including the broad range of issues addressed by rural providers, the lack of professional support (e.g., RNs and medical assistants), and the lack of back-up resulting in increased on-call frequency.
- Limited opportunities for continuing medical education.
- Inability of spouse to find a job;
- Assumptions related to schools, housing, the cost of living, and availability of amenities

As a result, Arizonans have access to fewer providers and encounter longer waits for needed services. In addition, Emergency Rooms inappropriately become primary care provider settings

Recommendation:

Establish a Recruiting Arizona Physicians (RAP) program office (s) to coordinate a statewide initiative designed to coordinate physician recruitment and help physicians establish their practices in underserved areas of Arizona. This represents a meaningful long-term solution, rather than a short-term stopgap measure. Through outreach and recruitment efforts, RAP office personnel would create a database of individuals in residency programs funded by AHCCCS

through GME, and out-of-state residents and physicians interested in moving to Arizona. Early, focused and ongoing communication with these individuals sends the message that Arizona is a state that is interested in supporting them, thereby increasing the likelihood that they will choose to practice in the State. This initiative could use both incubator and supply chain approaches to set these physicians up in practice in Arizona.

Taken from the medical term, an "incubator approach", as applied to the business setting, is an organization or environment that promotes growth and development of physician practices in the state. In the business sector "incubator programs" assist in the establishment and advancement of emerging businesses.

A statewide new physician incubator effort may be especially valuable in the ongoing effort to retain graduates of Arizona medical programs. The RAP would assist graduates of medical schools, both in and out of state, in securing placement for with a group of practitioners or community heath center to gain experience in operating a medical practice. The state could adopt this role alone, or could encourage one or more additional entities to operate it or in partnership with the state. To provide practical knowledge of practice management and procedures and offset the cost of the initial set up of a physician practice. For example, Federal Qualified Health Centers could act as administrators for such a program. Several Canadian medical clinics have established incubator programs to attract physicians to their practices. After a period of time, the group practice or clinic freely encourages them to either stay at the clinic or assists them in setting up private practices in the community.

The second approach applies supply change management principles to physician manpower shortage. Supply chain management is used primarily in managing good and services required to meet the needs of a business or organization. Applying this management concept to physician manpower shortage would mean that a "physician supply chain manager would be established to manage the supply of physicians to assure adequate supply of new providers for Arizona. In the "Supply Chain" approach, the RAP would work collaboratively with communities and the new physician to assist with the components needed to establish an independent medical practice.

The RAP would provide the following services, with the type and amount depending on whether the physician would be joining an existing practice or establishing a new medical practice:

- Practice management training
- Guidance on licensing requirements, malpractice insurance, property insurance, tax ID number, hospital privileges, MCO participation agreements
- Assistance with credentialing by AHCCCS and commercial health plans
- Assistance with acquiring AHCCCS and commercial health plan contracts
- Supply needs, including contract negotiations and providing an opportunity for discounted purchasing
- Locating and securing space, furniture & equipment, telephone systems, property insurance, utilities
- Determining the appropriate organizational structure for the provider (i.e., sole proprietorship, partnership, staff member)
- Information technology acquisition assistance

- Business operations requirements, such as billing, fee schedules, encounter forms, coding, staffing, policy manuals
- Confidentiality requirements, including HIPAA compliance
- Operational systems, such as appointment scheduling, medical records, lab operations, sharing of health information, marketing
- Assistance set up medical practice accounting systems
- Continuing Medical Education
- Contracts (for those joining practices)
- Linkages to community resources for information and assistance with issues such as housing, schools, recreation, vehicle licensure, voter registration, associations, etc.

Funding

This program would involve an initial monetary investment, as well continuing funds for administration. GME funds are proposed to be used to fund the RAP program. This would give allow the state to get federal matching dollars to support the program. Additionally, there may be a variety of funding sources available for local community sources if the issue can be approached as an economic one. Funding sources including economic development and practice enterprise funding, as well as federal and private grant funding.

The RAP program would need to be staffed to meet the needs of each region of the state. Depending on which concept (incubator or supply management) is used staffing and direct support cost will very. The level of support for each physician placement will be $45,000 to $75,000 per physician. Which include RAP program staff and set up practice support cost. Initial dollars to set up the program is estimated to be $150,000.
To meet the manpower shortage needs and to account for physician retirements the state we need to add at least 400 to 500 new physicians a year.

WORK FOR EMSA DRAFT REPORT
FOR DISCUSSION ONLY

EXECUTIVE SUMMARY

On April 26, 2006, Governor Janet Napolitano signed Executive Order 2006-09, forming the Emergency Medical Services Access Task Force ("EMSA Task Force"). The Executive Order recognized that Arizona faces increasing strain on its medical emergency and trauma systems, due in part to the combination of explosive population growth and national physician shortages. The Governor charged the EMSA Task Force with assessing the status of the physician supply available to hospital emergency departments and trauma services and developing recommendations to improve emergency and trauma care provided in our state. The Task Force found the following to be major contributing factors to the shortage of physicians serving Arizona's emergency departments and trauma centers:

1. ***Population Growth***

2. ***Increased Patient Volume***

3. ***Limited Physician Supply***

4. ***Shortage of Physicians Serving On-Call in Emergency Departments and Trauma Centers***

<u>The Task Force raised the following discussion items as potential remedies:</u>

1. ***Increase the Overall Supply of Physicians in Arizona***

2. ***Enhance Reimbursement for Physicians Serving in Emergency Departments and Trauma Centers***

3. ***Improve the Medical Liability Environment for Physicians Serving in Emergency Departments and Trauma Centers***

4. ***Utilize Technology to Enhance Resources Available to Physicians Serving in Emergency Departments and Trauma Centers***

5. ***Redesign the Relationship Between Hospitals and On-Call Physicians Serving in Emergency Departments and Trauma Centers***

6. ***Utilize Nurse Practitioners to Reduce the Pressure on Physicians Serving in Emergency Departments***

7. ***Provide Targeted Education for On-Call Physicians***

Applying their own experience and expertise, as well as information gathered by the members from various community resources, the EMSA Task Force developed a series of strategies to implement each of these recommendations. The remainder of this report discusses each of these strategies. Ultimately, no one strategy or goal will reverse the shortage of physician resources in hospital emergency departments and trauma centers. Stakeholders, including the public, will need to work collaboratively over time to make improvements and assure public access to quality emergency and trauma services throughout Arizona.

INTRODUCTION

Arizona's hospitals are experiencing unprecedented demands for emergency and trauma services. In part, this is due to the State's tremendous population growth – as of 2006, Arizona is the second fastest growing state in the nation. Along with this staggering rate of growth comes the need for diligent attention to assure that the state's emergency medical and trauma services infrastructure continues to meet the needs of Arizona residents and visitors. A particularly acute dimension of this issue is the worsening shortage of physicians available and willing to serve emergency department and trauma patients. Most Arizona hospitals do not employ the majority of physicians serving on their medical staffs. Hospitals therefore must rely on an adequate number of physicians choosing to become medical staff members and on medical staff bylaws and hospital directives that force medical staff members to serve periodically "on call" in the emergency department. A complex web of federal laws and regulations, reimbursement, liability and credentialing issues, and such matters as funding for graduate medical education, all influence physician availability and willingness. Because of the complexity of these influences, hospitals cannot solve the physician shortage alone. However, solutions may come from meaningful discussion among key stakeholders, including the public.

It is commonly accepted that Arizona hospitals already suffer from inadequate emergency room and inpatient capacity and an overall physician shortage. Because demand for access to emergency and trauma services will increase proportionately as Arizona's population grows, a comprehensive assessment and development of strategies is needed now. In order to accomplish this goal, in establishing the EMSA Task Force, Governor Napolitano brings together experienced stakeholders to address likely causes and make recommendations for meaningful improvements.

The EMSA Task Force is not alone in this effort. The Arizona Department of Health Services has formed several working groups to address related hospital overcrowding issues, including hospital throughput, diversion strategies, hospital surge capacity, education and best practices in emergency department management.

EMERGENCY MEDICAL SERVICES ACCESS TASK FORCE

Governor Napolitano issued Executive Order 2006-09 on May 25th 2006 to establish the Emergency Medical Service Access Task Force. The Executive Order specifically charges the EMSA Task Force with assessing the status of Arizona's Emergency Department and Trauma Center physician supply, identifying factors that may have lead to the current shortage, and making recommendations, including time frames, for actions the State may take to address the situation. The Governor has requested a full report of these findings and recommendations by January 1, 2007.

The members of the Task Force are experienced individuals interested in improving the quality of emergency care in Arizona. [identify each member to demonstrate relevant interest and experience]

Chair: Chris Skelly

Member:

Judith Berman

Bruce Bethancourt, MD

January Contreras

Mark Enriquez

Charles Finch

Susan Gerard, Director, Arizona Department of Health Services

Jim Ledbetter, President, Board of Trustees, Verde Valley Medical Center

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Msgr. Richard O'Keefe

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Pat Rehn

Tony Rodgers

Roy Ryals

Thomas Ryan

Donald Wayne, MD

Anne Winter

Staff Leadership:

Ron Anderson

DISCUSSION ITEMS RELATED TO TASK FORCE FINDINGS

The EMSA Task Force identified a set of core factors which they concluded are likely to have influenced the current shortage of physician providing medical emergency and trauma services. The following factors were identified as discussion items.

1. Population Growth

Arizona's population grew by 40% from 1990-2000. Population growth continues to outpace both healthcare facility construction and workforce training and recruitment. Twelve Arizona hospitals closed in the 1990's. Only fourteen hospitals are on track to be built during this decade.

Looking to the future, Arizona's elderly, the population with the greatest overall acute health care needs, will triple in size and represent 26% of the state's population by 2050. Based on current and projected population increases, Arizona will need at least 10 additional hospitals (above those already on track to be built (?)), over the next 10 years. (Information provided by Dr. Finch, sources being sought.)

Finally, Arizona's large uninsured population is likely to increase proportionally to the increase in the overall population.

2. Increased Patient Volume

With increased population inevitably comes an increased volume of patients in emergency departments and trauma centers. The result is a greater need for physicians to serve those patients, both in the emergency departments themselves and during the inpatient hospital stays that follow for some patients. One component of increased patient volume believed to have an especially significant impact on emergency department crowding is the surge in patients needing urgent psychiatric care services.

For most hospitals, the sheer number of patients makes it difficult and sometimes impossible to provide care for emergency department patients in a timely manner. It also leads to a much increased burden in time and uncompensated care for busy physician specialists serving the emergency department periodically through an on-call schedule.

3. Limited Physician Supply

While this report focuses on the shortage of physicians in the state's emergency departments and trauma centers, it is indisputable that this shortage is directly tied to the overall inadequate supply of physicians. The problem has been noted in Arizona and nationwide, related to factors including stagnant medical school and residency numbers and declining reimbursement for physicians. [Citation].

The EMSA Task Force attributes Arizona's physician shortage to a number of factors. Because close to a majority of physicians who attend residency programs in Arizona later practice medicine in the state, an important factor is limited graduate medical education funding, which directly affects the number of resident slots in Arizona residency programs. The Task Force also identified for discussion the notion that the state's medical liability standards may make Arizona less attractive than other locales for new physicians. Barriers to licensing and managed care credentialing appear to be additional important factors in Arizona's physician shortage.

4. Shortage of Physicians Serving On-Call in Emergency Departments and Trauma Centers

The EMSA Task Force noted an increasing complaint among hospitals about the decreasing numbers of physicians available and willing to serve on-call in emergency departments and trauma centers. Task Force members identified several factors that may deter physicians from serving in an emergency department or trauma center. The overall shortage of specialists in certain disciplines appears to be exacerbating the shortage of on-call physicians for service in emergency departments and trauma centers.

Beyond that, physicians often find emergency service unattractive because it involves disruption to both personal life and private practice.[1] The federal EMTALA law and regulations currently require hospitals (and their on-call physicians) to accept emergency transfers from hospitals and communities across the state and beyond.[2] Once they have evaluated and treated patients in the emergency department, physician ethical obligations may mean that physicians continue to see these patients for some time, frequently without reimbursement. In some instances, such follow-up care is made more difficult by the patient's insurance plan or failure to follow discharge instructions.

To cope with these concerns, physicians are increasingly obtaining selective or narrow medical staff privileges in hospitals. Such a choice reduces the physician's capabilities to serve patients in the emergency department.[3] Moreover, some specialists have the ability to perform their more lucrative procedures outside of the hospital setting in facilities such as specialty surgical hospitals or other ambulatory care settings, reducing the need for medical staff membership altogether.[4]

DISCUSSION ITEMS RELATED TO TASK FORCE RECOMMENDATIONS

EMSA Task Force members each provided recommendations to the Task Force identifying actions the State may take to address the shortage of physicians in Arizona's emergency departments and trauma centers. Task Force members generated a variety of recommendations for discussion, including:

1. Increase the Overall Supply of Physicians in Arizona

The shortage of on-call physicians for emergency department and trauma services is directly tied to the overall shortage of physicians. Task Force members believe that increasing the number of physicians in the state could increase the pool available for emergency department and trauma services. Discussion items include:

Increase Funding for Graduate Medical Education

- The goal is to increase the number of resident slots, so that a larger number of residents will complete their training in Arizona. Current data suggests that approximately 40-60% of new physicians will remain in the locale where they completed their residencies.

[1] See e.g., American College of Surgeons, *"A Growing Crisis in Patient Access to Emergency Care"* (June 2006).
[2] See e.g., American College of Surgeons, *"A Growing Crisis in Patient Access to Emergency Care"* (June 2006).
[3] See e.g., American College of Surgeons, *"A Growing Crisis in Patient Access to Emergency Care"* (June 2006).
[4] See e.g., Mitchell, J.M., *"Effects of Physician-Owned Limited Service Spine and Orthopedic Hospitals in Oklahoma,"* Georgetown University Public Policy Institute (April 26, 2005).

- Provide additional education and assistance to new physicians to assist them in such practical obstacles as joining or opening a medical practice and obtaining managed care contracts.

Attract Physicians from Out-of-State

- Provide "one-stop shopping" service for licensure and credentialing for physicians who wish to practice in Arizona.

- Provide assistance for physicians relocating to Arizona (*e.g.,* real estate agent referrals, physician market information, business assistance and favorable loan terms to physicians who wish to practice in Arizona).

- Market Arizona as an attractive place for physicians to practice.

Reduce Obstacles to Medical Practice in Arizona

- Expedite and streamline the licensure process in the two state physician licensing boards.

- Require managed care companies to reduce their initial credentialing time.

- Require managed care plans to promptly provide retroactive reimbursement for services physicians render to plan subscribers before the physician credentialing process is completed.

Utilize the retired and part-time physician workforce

- Reduce or eliminate the malpractice requirements placed upon these physician resources.

2. Enhance Reimbursement for Physicians Providing Emergency Department On-Call and Trauma Center Services

EMSA Task Force members believe the shortage of on-call physicians available and willing to provide for emergency department on-call and trauma services could be reduced through appropriate and targeted reimbursement. Discussion items include:

Provide tax incentives for on-call physicians

- Provide tax incentives or tax credits to licensed Arizona physicians related to the provision of on-call services. For example, such

physicians could receive tax credits related to otherwise uncompensated care they provide, or related to their malpractice premiums.

Provide AHCCCS Supplemental Reimbursement

- Provide supplemental AHCCCS reimbursement to licensed Arizona physicians related to the provision of on-call services to AHCCCS beneficiaries.

Redesign Relationship between Managed Care Plans and On-Call Physicians

- Require managed care plans to streamline their credentialing processes for *locum tenens* physicians who provide on-call services to managed care plan beneficiaries.

- Require managed care plans to reimburse non-contracted physicians for the provision of on-call services to managed care plan beneficiaries.

- Require managed care plans to allow non-contracted on-call physicians to provide follow-up care to patients initially seen in the emergency department or trauma center and reimburse non-contracted physicians for such follow-up care.

3. Improve the Medical Liability Environment for Physicians Who Provide Emergency Department On-Call and Trauma Center Services

EMSA Task Force members believe the shortage of on-call physicians available and willing to provide for emergency department on-call and trauma services could be reduced through an improved medical liability environment. Understanding the substantial state constitutional barriers to comprehensive medical malpractice reform, discussion items include:

Reform State Law in the Area of Medical Liability for On-Call Physicians

- Increase the burden of proof to “clear and convincing evidence” in civil medical liability cases filed against physicians providing EMTALA-mandated care in emergency departments or in a disaster.

- Provide state-funded medical liability coverage for any extra premium paid by physicians providing emergency department on-call or trauma centers.

- Increase the required qualifications for expert witnesses testifying against on-call physicians.

- Petition the Arizona Supreme Court to authorize jury instructions educating juries regarding the unique environment in which on-call physicians practice in the emergency department.

Reform Regulations in the Area of Medical Liability for On-Call Physicians

- Address medical liability insurer disincentives to physicians providing on-call coverage.

- Clarify Arizona Medical Board and Arizona Osteopathic Board ethical guidelines with respect to the provision of follow-up care by on-call physicians, including time frames for such care.

4. Utilize Technology to Assist Physicians Providing Emergency On-Call and Trauma Center Services

EMSA Task Force members believe the work environment for physicians providing services in emergency departments and trauma centers could be improved through routine use of electronic health records and telemedicine technology. Discussion items include:

- Implement standardized, comprehensive electronic medical records for use in emergency departments and trauma centers.

- Increase the use of telemedicine in emergency departments and trauma centers to help reduce the need for patient transfers.

5. Increase the Use of Nurse Practitioners

EMSA Task Force members believe emergency and trauma services workloads could be better distributed by effective utilization of nurse practitioners. In addition, recognition of nurse practitioners as independent practitioners in the field will help reduce the need for emergency department services. Discussion items include:

- Require AHCCCS to permit independent nurse practitioners to participate in the AHCCCS program, similar to the Medicare reimbursement methodology for these practitioners.

- Require managed care plans to reimburse nurse practitioners for independently providing provide services in emergency departments and trauma centers.

- Promote efficient use of nurse practitioner services in emergency departments and trauma centers.

- Increase the availability of nurse practitioners educated in intensive care unit and emergency care.

6. Redesign the Relationship Among Communities, Hospitals and Physicians Providing Emergency On-Call and Trauma Center Services

Current law and practice requires each individual hospital to provide emergency department coverage for its own patients. EMSA Task Force members believe systemic changes could better ensure sufficient access to care in emergency departments and trauma centers. Discussion items include:

- Authorize the establishment of a combined physician specialist call rotation for all facilities within a geographic area, utilizing a "center for excellence" approach similar to the approach taken by trauma centers and the Arizona Perinatal Trust.

- Develop or authorize shared, community, or regional on-call arrangements in specialties with limited on-call physician availability.

- Limit physician ability to obtain selective or narrowed medical staff privileges if doing so limits their ability to provide frequently needed on-call services.

- Require physicians who provide services in ambulatory surgical centers or licensed outpatient treatment centers, or who provide high risk surgical procedures in private physician offices to maintain active medical staff membership in at least one hospital. This could reduce physician flight from hospitals due to on-call requirements, and ensure that patients transferred from those outpatient settings with emergency conditions will have attending physicians. Require managed care plans to assure the availability of sufficient numbers of on-call physicians at network hospitals to provide emergency and follow-up care services to insured patients. Under this approach, insured patients would never or rarely be treated as "unassigned patients" for on-call purposes.

- Develop disincentives for hospitals to transfer patients when the transferring hospital has the capability to provide patient care services.

7. Provide Targeted Education for Physicians Providing Emergency On-Call and Trauma Center Services to the Community

EMSA Task Force members believe the shortage of on-call physicians for emergency department and trauma services could be reduced through increased education for emergency department physicians. Discussion items include:

- Provide targeted specialty education for emergency department physicians to increase levels of expertise in common services needed in emergency departments (*e.g.,* behavioral health, orthopedic).

- Provide targeted education for rural physicians to increase levels of expertise in designated specialties to reduce the number of patient transfers from rural hospitals.

- Provide community education regarding the proper use of hospital emergency departments.

Presented by: Richard Polheber
Prepared draft: 1 August 2006

EMERGENCY MEDICAL SERVICES ACCESS TASK FORCE --ALTERNATIVES FOR ACTION

A. BACKGROUND

The overcrowding of patients visiting emergency Rooms is created in part by some of the following factors: 1. Citizens without insurance who have no primary care physician and elect to use the emergency room as a place to seek their urgent and none emergent medical assessments. In some instances, these individuals defer access to care until the early indications of a problem have developed into a significant medical emergency. 2. Citizens with health insurance find the availability of a timely appointment to their primary care physician impossible and elect to go to the emergency room (and in some instances are actually sent by the primary care physician or the office staff). 3. The crowding and delays in the Emergency Room also are impacted by the often challenges of downstream availability of beds which required acute care management by staff within the Emergency Room. 4. The extended stays in the Emergency Room are also caused by the shortage of Specialty physicians and their inability to respond on a timely basis to the Emergency room to provided additional assessments.

It should be pointed out that some of the down stream access problems are shortages of nursing personnel. A subject which was addressed by the Arizona State Legislature several years ago with a proposal to expand the capacity of nursing programs in the State of Arizona. While progress in being made in this area, it will take several years to cover the current shortage much less prepare for the expected growth in the population of the State. While additional work is needed in this area, it is not the focus of this paper.

The shortage of physicians (both primary and Specialty) is created in part by some of the following factors: 1. The financial opportunity for like types of practices are superior in other states. Some of the contributing forces: the high penetration of managed care and the apparent gap in reimbursement for services provided in comparison to other areas of the country, the number of citizens without health insurance and their inability or unwillingness to pay for services out of pocket, the cost of medical liability insurance, and perceived stresses in working/taking call in the environment that has been created by all these forces. 2. The significant delays associated with the ability to be fully engaged in a practice because of the time it takes to get licensed in the State and to become privileged in all the health plans within a local region (there are examples where this takes up to a year to complete the process). 3. The shortage is even more extensive for the Emergency Room and the acute care units of a hospital because a growing number of Specialty Physicians no longer feel compelled to hold Medical Staff Privileges because many of the services historically provided in the hospital can now be performed in their office or other ambulatory care settings.

The State of Arizona is facing issues of reasonable income expectations for physicians, recruitment, and retention issues.

B. ACTION ITEMS

While there are a number of initiatives which could be pursued by the State of Arizona, the following three categories of focus are offered for consideration:
1. Improve the Medical Liability Climate of the State. While total reform is desirable, an immediate fix would be a protection for physicians who see unassigned patents in the Emergency room. This protection could be a limit on payments for cases litigated for care in the emergency Room. Or the development of requirement that patients seeking care in the emergency room would be required to sign a waiver which would require any resolution issues being settled by a state wide compensation panel (developed by the State Legislature) who would set compensation recovery limits in cases of unanticipated injuries.

2. Improve the annual income earning of physicians. Provide a tax incentive for primary care physicians who locate to Arizona and practice for a specified number of years and for Specialty Physicians (develop a specific list of eligible specialty areas, e.g. Neurosurgery, hand surgery, general surgery, GI) who provide "X" number of 24 hour period of coverage and accept all referrals in a Hospital Emergency Room. This incentive would be a direct reduction in the state income tax collected with an income tax filing including necessary documentation from the Hospitals for the Specialty Physicians and relocation information for Primary Care Physicians. The tax reduction has to be seen as sufficiently large that it would be a motivator for action. Another initiative would be to develop an incentive pool to compensate physicians who provide charity care in the Emergency Room---this could be administered in partnership with the Hospitals. And legislate time frames for Manage Care Plans to complete the privileging process---currently hospital are expected to complete within 90 days.

3. Reduce visits to the Emergency Room

The action taken above to expand the number of Primary Care Physicians who elect to come to Arizona will a positive impact in reducing visits and crowding in ER's. In addition, the State should advocate for Federal Action to Expand the number of health centers throughout the state. This effort should be focused on the expansion of the current federally funded health centers as well as the leveling of the playing d for other centers who are providing comparable services.

Status Report

Statewide Strategic Plan for Nursing

Prepared for
The Honorable Janet Napolitano
Governor of Arizona

Prepared by
The Arizona Governor's Task Force on the Nursing Shortage

January, 2006

History:

The State of Arizona is facing a shortage of registered nurses (RNs) that was reaching a crisis of critical proportion. In 2001, in recognition of this crisis, Governor Hull appointed the Governor's Task Force on the Nursing Shortage. In 2002, under the leadership and administration of Governor Janet Napolitano, the Task Force was charged with the development of a statewide strategic plan targeting the multiple and complex factors involved with the shortage of RNs. This plan was completed in 2005, and members of the task force continued to work until objectives from the plan were completed or well on a path of completion. This report is a summary of outcomes of the work plan developed by the Task Force.

Accomplishments:

The supply of registered nurses has increased in both the United States and Arizona. The U. S. Department of Health and Human Services recently released a preliminary report from the 2004 National Sample Survey of Registered Nurses which indicated that Arizona has improved its ranking to 45th from 48th in the United States for employed RNs per 100,000 population. Only California, Nevada, Texas, Idaho, and Utah had lower ratios of employed nurses to population. However, the average age of nurses in the US has increased from 45.2 to 46.8 years.

The task force addressed issues contributing to the nursing shortage in Arizona. Most of our accomplishments reflect the development of programs increasing the number of new nurses and retaining nurses currently working in healthcare.

Below is a sample of accomplishments and completed strategies from the statewide strategic plan developed by the Task Force:

- Increased number of applicants for RN licensure

Type of application for RN license	2001	2003	2005
NCLEX-RN (exam)	610	1483	1925
New endorsement (from other state)	803	2628	4129
Total:	**1,413**	**4,111**	**6,054**

Source: Arizona State Board of Nursing

- Significant growth of nursing student enrollment in community colleges and universities. There has also been a growth in the number of approved nursing programs in the State, both public and private. There continues to be a critical shortage of qualified faculty and extremely crowded clinical settings for students.
- Establishment of a program to prepare internationally educated nurses for RN licensure. These nurses reside legally in the U.S. Twenty-five foreign educated, bilingual nurses successfully completed the program at Mesa Community

College. Six nurses gained RN licensure, 11 are waiting to take the RN licensure exam. The remaining graduates are waiting the credential review necessary to apply for licensure. This program received a three-year grant from HRSA beginning July, 2005. A second cohort is progressing through the program. These nurses are from Mexico, Colombia, Philippines, Bosnia, Poland, and Iran.

- Application to the National Centers for Nursing completed. This will establish a virtual Arizona Center for Nursing, supported by multiple stakeholders (AzHHA, AzONE, AzNA, Arizona State Board of Nursing, etc.) Membership within this national network will provide comparative data, workforce prediction models, grant information, and other valuable information. By establishing a virtual Center, the cost will be kept at a minimum.
- Funds acquired for nursing research position at the Arizona State Board of Nursing. This position is instrumental in securing and maintaining a central repository of information that can be used to make decisions and recommendations to various stakeholders.
- Legislation passed in 2005 provides $20 million to the State's universities and community colleges. The signing of SB 1294, the Arizona Partnership for Nursing Education (APNE) targeted funds to increase nursing faculty thereby increasing the number of nursing graduates from state supported higher education programs.
- Diversity grant from HRSA received by AzHHA. The intent is to increase retention and graduation of minority nursing students and to attract more diverse youth into healthcare.
- Educational partnerships developed between industry groups to increase the number of graduating nurses and decrease length of time to graduation.
- Increased number of hospitals providing on-site RN to BSN programs. Efforts to increase the percentage of baccalaureate prepared nurses in Arizona include streamlined articulation between AAS and BSN degrees; community college baccalaureate initiatives; partnerships such as the ASU-Maricopa Community Colleges Alliance, the Healing Community (NAU and rural community colleges), and others.
- Establishment of Tier I and II of the Arizona Healthcare Leadership Academy.
- Establishment of a pilot program to evaluate the use of certified medication technicians in long term care settings.
- ASU College of Nursing's Center for Advancement of Evidence-Based Practice coordinated the establishment of the Arizona Consortium for the Advancement of Evidence-based Practice (AZCAEP), representing over 50 hospitals/healthcare agencies throughout Arizona. The mission of AZCAEP is to improve healthcare quality, patient outcomes and increase nurse satisfaction through evidence-based practice (EBP).
- Conducted preliminary survey addressing variables impacting nursing care delivery in acute care and correctional settings. Chief nursing officers completed the questionnaire with results received from metropolitan and correctional settings only. A summary of the study findings is included as Appendix B.

While these accomplishments are notable, the nursing shortage is far from over and additional strategies must be urgently undertaken to prevent a healthcare crisis in the next decade. Several new factors have come into play. These new factors include:

- Arizona's rapid growth
- aging baby boomer population
- increases in acute care beds
- other healthcare workforce shortages
- high levels of dissatisfaction with the nursing profession and the work environment, leading to high turnover and vacancy rates.

The effect of these factors combined with issues previously considered by the Task Force, lead to the following future recommendations.

Recommendations:

The nursing shortage is far from over. The work of this Task Force would not be complete without recommendations for the future. These recommendations build on programs in progress and other identified needs. The following represents future strategies and programs:

- Work with federal legislators to secure federal match for APNE Demonstration Project (SB1294).
- Expansion of the preliminary study on the variables impacting nursing care delivery to include long term care, out patient and ambulatory care and home health. Future studies need to address other nursing employment environments.
- Fund a multi-site study through AzCAEP to test the effects of placing advance practice nurses as EBP mentors in healthcare settings on nurse satisfaction, EBP beliefs, implementation, and nurse retention. This study would support the findings that EBP has improved healthcare quality as well as patient outcomes, and could serve as a key strategy for increasing nurse satisfaction and decreasing turnover.
- On-going financial support for the Arizona Center for Nursing
- Monitor and evaluate results from the Med-Tech Pilot Study

State wide nursing leadership is committed to implementing and monitoring these recommendations. Future state and federal legislation would address the funding recommendations.

Appendices:

Strategic Map for Nursing Status Report
Preliminary Study Results

Appendix A

Strategic Map for Nursing Status Report

January, 2006

Strategic Map for Nursing				
Theme	**Activity**	**Expected Outcome/Date**	**Responsible Party**	**Update / Status January 2006**
Attracting People to the Profession	Identify the number of nurses and nursing assistants needed in various practice settings by geographical location, educational preparation and ethnicity.	Report on number of nurses and nursing assistants needed geographically, and by educational preparation, by December 2004.	Rose Conner, Kathy Malloch, Peggy Mullen, Fran Roberts, Marla Weston, Lynn Maschner	~ Have identified issues in the availability and consistency of data. ~ Considering a comprehensive data repository. Research position at Arizona State Board of Nursing funded, will continue this work. **CLOSED**
	Implement centralized information for students on waiting lists to access information on openings in schools through ASBN website.	Available nursing education openings routinely listed on website by August 2004.	Joey Ridenour	~ Discussions for the development of a public access web based table that includes the following data elements: 1. School name 2. Cohort start date 3. # students applied 4. # students qualified 5. # students admitted 6. If hospital based program ~ Need to develop mechanism to identify duplicate applicants. Research position at Arizona State Board of Nursing funded, will continue this work. **CLOSED**
	Design strategy for retaining people on waiting list.	Issue reviewed briefly at Oct. 05 meeting. Outcomes and date information will be provided once responsible party determined.	Not assigned – pending response from group.	**At the Oct. 05, 2005 update session this issue was decided to have its own activity block as it will require resources to address.**

Strategic Map for Nursing				
Theme	**Activity**	**Expected Outcome/Date**	**Responsible Party**	**Update / Status January 2006**
	Determine, through a longitudinal study, if people on waiting lists remain interested in pursing a career in nursing or have changed career paths.	Plan developed to counsel individuals currently on education program waiting lists.	Pat Harris, Joey Ridenour, Jean Stengel	~ Developing a plan that will communicate what school programs currently have student openings so student options are available. Data will ideally be linked to above referenced web based table. **Research Position at Arizona State Board of Nursing will collect data on duplicate applications to establish an accurate number of students waiting.** **ONGOING—Educational programs to work on retention of waiting students.**
	Identify strategies for attracting a more diverse population and more bilingual individuals to nursing.	Marketing campaign developed and implemented for attracting diverse populations and bilingual individuals to nursing by 2006.	Adda Alexander	~ Through the AzHHA HRSA grant, a 2 day conference on diversity training was held for instructors so minority student nurses will be retained. ~ Acquiring list of media contacts for minority based media ~ Launched nurse story telling project featuring minority nurses Recruitment of students has been successful, diversity efforts continue. **CLOSED**
	Continue to monitor number of individuals entering programs and number on waiting lists.	Annual report to nursing community by December 2004.	Joey Ridenour	~ Continue to monitor and part of routine reporting process. **CLOSED**

Strategic Map for Nursing				
Theme	**Activity**	**Expected Outcome/Date**	**Responsible Party**	**Update / Status January 2006**
Educating More Nurses	Monitor and collaborate on fundraising and plan development for Nursing Education Program and Expansion Plan.	Plan developed to identify $111 million over the next five years for increasing educational capacity.	Fran Roberts, Marjorie Isenberg	~ SB 1294 funded bringing $20 million for education staff (not for capital expenses). AzHHA will continue their efforts and try to get matching Federal funding. Capacity increasing as forecasted. ~Group to meet to develop additional strategies **CLOSED**
	Address the faculty shortage and the non-competitive salary structure of nursing faculty to meet current and future faculty demands.	Develop a plan for attracting nurses to faculty positions including (1) outline for adjusting salaries to meet market demands and (2) prediction of number of faculty needed based on growing demand and retirement projections.	Marjorie Isenberg, Pat Harris, Fran Roberts, Judy Sellers	~ SB 1294 funded $20 million for salary impacts with faculty – both to acquire new staff and make salary ranges competitive and attractive. ~ Predictive model being explored. Nurse Researcher position at the Arizona State Board of Nursing Researcher will include faculty needs in predictive model under development. **ONGOING—Analysis of issue will be done through the Center for Nursing.**

Strategic Map for Nursing				
Theme	**Activity**	**Expected Outcome/Date**	**Responsible Party**	**Update / Status January 2006**
	Explore strategies for increasing alternatives for educating more nurses while maintaining current standards.	Strategies identified for increasing alternatives for educating more nurses while maintaining current standards.	Pat Harris, Jayne Wilkins, Fran Roberts, Marty Enriquez, Richard Patze	~ A significant number of collaborative, creative and innovative programs have been developed through partnerships with hospitals. Workgroup continues to catalog these efforts. ~ All four Universities have developed fast track programs for 2nd degree RNs. Three of the four have been implemented. **CLOSED**
	Implement program to assist foreign educated nurses to successfully complete NCLEX.	Program graduates first class by August 2005.	Bertha Sepulveda	~ Graduated first cohort in August 2005. Inquiries for this program have been received from around the world. First cohort has provided great feedback and "lessons learned" for following cohorts to assure success and satisfaction. The second cohort began in August, 2005. **CLOSED**
	Evaluate the merits of baccalaureate nursing education through the state's community colleges.	Nursing community recommendation for increasing baccalaureate nursing education in Arizona.	Marla Weston, Kathy Malloch	~ Day of Dialogue occurred in Nov. 2004. ~ Legislative efforts initiated on 2005 and will continue in 2006. **CLOSED**

Strategic Map for Nursing				
Theme	**Activity**	**Expected Outcome/Date**	**Responsible Party**	**Update / Status January 2006**
	Explore HRSA, WIA (workforce investment act) and other funding for enhancing preceptor development.	Apply for a grant that enhances recruitment and retention of nurses.	Mardy Taylor, Adda Alexander, Marty Enriquez, Rose Conner	~ AzHHA HRSA grant will have an option next year for a three-year extension. If granted, will contain preceptor component. **CLOSED**
	Clarify and enhance the work of preceptors. Enhance support in the work environment to orient and mentor students, new graduates, new employees traveling nurses, and programs to transition experienced nurses to new settings.	Create and disseminate template for model orientation, precepting, residency and mentoring programs.	Sandy Hughes	~ Arizona Healthcare Human Resources Association (AHHRA) is collecting data and program information from various existing programs across the nation. (DONE) ~ Will be conducting evaluation process of data obtained and making recommendations. (DONE) **CLOSED. Promising Practices will be posted on the internet at a web site to be determined.**

Strategic Map for Nursing				
Theme	**Activity**	**Expected Outcome/Date**	**Responsible Party**	**Update / Status January 2006**
	Establish practices for transitioning new graduates into competent RNs.	Evaluate pilot residency program and incorporate into model precepting/residency program. Evaluate a national pilot residency program and a change in hours worked from 12 hour down to 8 hour shifts.	Sandy Hughes, Marjorie Isenberg, Marty Enriquez	~ University Medical Center (UMC) participated in National pilot program. ~ Program results shared at the Arizona Nurses Association convention in September 2005. **CLOSED**
	Identify excellent preceptors as future faculty.	Delineate criteria for selecting preceptors as future faculty and disseminate to clinical professors.	Linda Hunt, Fran Roberts, Lynn Maschner	~ UMC developing a program that could be shared. St. Joseph's Medical Center has also developed a model. ~ Information gathered regarding three unique programs for new grad mentoring / preceptorships. Costs and resources vary between programs. This information will be posted on the AzONE, AzNA and AzHHA websites. **CLOSED**

Strategic Map for Nursing				
Theme	**Activity**	**Expected Outcome/Date**	**Responsible Party**	**Update / Status January 2006**
Improving the Work Environment	Focus on improving the work environment in three areas where most nurses work: hospitals, long-term care, home health, hospice.	Share best practices on creating a positive work environment from different employment settings. Develop materials to help health care organizations implement desirable nursing practice environments (repository of information)	Jayne Wilkins, Adda Alexander, Peggy McMacken, Peggy Mullan, Judy Sellers	~ Individual organizations collecting best practice data ~ Workgroup to meet to review data and collate work. Intend to compile for distribution. HCI workgroup on Best Practices/Promising Practices established. Results will be posted on web. **CLOSED**
	Promote educational session by AzNA on "what it means to be a professional nurse."	Increase presentations to clinical nurses, emphasizing the important contributions of nursing's voice and expertise.	Marty Enriquez, Marla Weston	~ Continued education provided through Arizona Nurses Association and Professional Advocacy ~ Program results shared at the Arizona Organization of Nurse Executives September 2005. **CLOSED**
	Establish reward mechanisms for best practice facilities, including AzNA recognition and nomination by clinical nurses.	Expand existing award program to increase participation in nominations and recognitions.	Marla Weston	~ Awards given by the Arizona Nurse Association. **CLOSED**

Strategic Map for Nursing				
Theme	**Activity**	**Expected Outcome/Date**	**Responsible Party**	**Update / Status January 2006**
	Establish an Arizona Center for Nursing as a venue for data collection on nursing to serve as a centralized repository of information on nursing and to provide resources for assisting nurses to navigate regulatory agencies.	Development of process and reports for reliable data about the need for nursing including projections for practice and education.	Marla Weston, Kathy Malloch, Pat Harris	~ Arizona Board of Nursing taking the lead on this and has been approved for one FTE to start the process. HCI will file to become a Workforce Center within national network of centers. Once accepted, an organizational structure will be established in cooperation with all stakeholders. Arizona State Board of Nursing Researcher position funded and will be hired. **CLOSED**
	Continue to monitor activities in other states related to initiatives.	Communicate information to Arizona nurses	Marla Weston	~ Arizona Nurses Association continues to monitor and distribute information to the nurse membership via their electronic newsletters every other week. **CLOSED**
	Promote leadership education for clinical nursing supervisors.	Modify program based upon pilot and expand to statewide implementation by December 2004.	University of Arizona College of Nursing and Business, Marla Weston	~ Arizona Nurses Association continues to provide training through the Arizona Healthcare Leadership Academy program. ~ Six programs completed and additional offerings are scheduled. **CLOSED**

Strategic Map for Nursing				
Theme	**Activity**	**Expected Outcome/Date**	**Responsible Party**	**Update / Status January 2006**
Removing Regulatory Barriers	Evaluate data collected on barriers to foreign educated nurse licensure.	Data evaluated at the end of the first cohort completing the program by August 2005.	Bertha Sepulveda	~ First cohort graduated in August 2005. Second cohort admitted August 2005. **CLOSED**
	Implement medication technician pilot study.	Implemented by August 2005.	Peggy Mullen	~ Curriculum, criteria for facilities and program protocols are developed. ~ Seeking funding sources ~ Six Long Term Care facilities are involved and supporting the program. Arizona State Board of Nursing will conduct research on Certified Medication Technician and patient safety and report to Legislature outcomes of the study in 2007. **CLOSED**
	Continue to monitor for other regulatory barriers.	Barriers identified on ongoing basis.	Joey Ridenour	~ Monitor as needed **CLOSED**

Appendix B

Preliminary Study Results

Findings from Survey of Hospitals and Correctional Facilities in Arizona

February, 2006

Status Report: Major Findings from a Recent Survey of Hospitals and Correctional Facilities in Arizona
February 7, 2006

Survey of the current state:

In order to present the current status of nursing across Arizona and potential factors influencing the shortage, a survey was developed and disseminated to chief nursing officers (CNOs) of 84 hospitals across the state in December of 2005. Forty surveys were returned (i.e., a response rate of 47.6%).

Thirty-one of the 38 CNOs (86.9%) who responded to the question regarding their age reported that they were 41 years of age and above, with the greatest number of individuals (n=19) ranging in age from 41 to 50 years.

Thirty-one of 39 (79.5%) of the CNOs who completed the question regarding education reported that they had a master's degree, with 6 reporting a baccalaureate degree, and 2 reporting a doctorate as their highest level of education.

Results from this survey indicate the following findings:

Status of Hospitals

Variable	Mean	Number of Responses	Standard Deviation	Minimum	Maximum
Current RN vacancy rate, as a %**	15.8	35	13.6	0	50
Current RN turnover rate, as a %	14.9	39	7.6	.5	32.6
Number of budgeted patient beds	209	38	193	0	776
Number of patient beds unfilled due to the lack of RNs	11.3	27	23.6	0	112
Percent of budgeted beds that are unfilled	8.0	27	14.4	0	50
Percent of RN direct care staff that is baccalaureate prepared	37.6	31	19.9	.5	100

Percent that RN salaries have increased since 2001	23.1	32	19.9	0	100
Bonuses for new hires	$4,214	7	$2,270	$1,000	$8,000

**The average national RN vacancy rate is currently estimated at 13%, with 14% of hospitals nationwide reporting RN vacancy rates higher than 20%. In this survey, 28% (10 of 35) of the responding hospitals reported RN vacancy rates higher than 20% (retrieved from www.aacn.org/_882565100000a416nsf/ on January 25, 2006) and 9 of 39 hospitals (23%) reported RN turnover rates higher than 20%.

Nineteen of 38 responding hospitals stated that they offered bonuses for new hires.

Two of the hospitals reported that they have achieved magnet status, with 15 hospitals reporting that they are planning a magnet application.

Eighteen of 39 responding hospitals reported that they sent staff to the AZ Healthcare Leadership Academy in the last 2 years. Feedback provided on the academy was very positive. Sending staff to the Leadership Academy was correlated with having established RN staff ratios (r = .31).

Twenty-five of 38 responding hospitals reported that they had established RN staffing ratios. The most common responses were a ratio of 5-6:1 for medical surgical units; and 1-2:1 for critical care units or emergency departments.

Status of Correctional Facilities

In addition to the 40 hospitals that returned completed questionnaires, two correctional facilities responded to the survey. Results from their responses are as follows.

Variable	Mean	Number of Responses	Standard Deviation	Minimum	Maximum
Current RN vacancy rate, as a %**	35.0	2	7.07	30.0	40.0
Current RN turnover rate, as a %	31.5	2	12.02	23.0	40.0
Number of budgeted patient beds	5102.5	2	6296.11	205	10,000
Number of patient beds unfilled due	0	1		0	0

to the lack of RNs					
Percent of budgeted beds that are unfilled	0	1		0	0
Percent of RN direct care staff that is baccalaureate prepared	31.5	2	26.16	13.0	50.0
Percent that RN salaries have increased since 2001	2.4	2	3.32	0	4.7
Bonuses for new hires	0	2		0	0

Status of Rural Hospitals

Four of the hospitals were identified as being in rural areas. A summary of their responses is presented in the following table.

Variable	Mean	Number of Responses	Standard Deviation	Minimum	Maximum
Current RN vacancy rate, as a %**	4.4	3	5.30	0	10.3
Current RN turnover rate, as a %	10.8	3	5.19	6.0	16.3
Number of budgeted patient beds	101.0	3	142.12	14	265
Number of patient beds unfilled due to the lack of RNs	13.3	3	23.1	0	40
Percent of budgeted beds that are unfilled	5.0	3	8.71	0	15.1
Percent of RN direct care staff that is baccalaureate prepared	24.3	4	22.49	3.0	50.0
Percent that RN salaries have	48.7	3	44.5	21.0	100.0

increased since 2001					
Bonuses for new hires		0			

Findings Regarding Evidence-Based Practice:

Twenty of 37 hospitals (54%) responding stated that EBP is currently written in the philosophy of their institutions.

Thirteen of 38 hospitals (34%) responding stated that they have one or more advanced practice nurses who function as EBP mentors.

Twenty-six of 36 hospitals (72.2%) responding reported that the staff nurses consistently implement EBP ranging from "not at all" to "somewhat." The other 10 hospitals reported that their nurses implemented EBP "moderately so" to "very much so."

Eighteen of 32 CNOs (56.3%) reported that they believed "moderately so" or "very much so" that staff nurses who implement EBP have higher job satisfaction.

Thirty one of 35 CNOs (77.5%) reported that they believed that EBP improves patient outcomes moderately so or very much so.

Sixteen of 36 CNOs (44.4%) reported that there are specific criteria regarding EBP on nurses' performance evaluations.

Thirty-three of 39 CNOs reported that they measure staff nurse satisfaction. The most commonly reported measures were the NDNQI and employee satisfaction surveys.

Other Important Findings

Age of the CNOs was significantly correlated with the current RN turnover rate at -.32 in that CNOs who were older reported less turnover. In addition, the older the CNO, the fewer percentage of baccalaureate prepared nurses were in their system ($r = .386$).

Education of the CNOs was negatively correlated with RN vacancy rate at -.517 in that higher educated CNOs reported less turnover.

Nurses who reported stronger beliefs that their nurses were consistently implementing EBP reported that they believed that staff nurses who implemented EBP had higher job satisfaction ($r = .693$).

Hospitals who had EBP written as a philosophy in their institution were more likely to have established RN staffing ratios ($r = .33$) and have specific criteria related to EBP on performance evaluations/clinical ladder system for staff nurses (.67).

Although not statistically significant due to limited statistical power of the small sample size, hospitals who had one or more advanced practice nurses functioning in the role of an EBP mentor (n=12) had a lower RN vacancy rate (12.3%) than those who did not not have advance practice nurses in this role (n=21) (RN vacancy rate = 18.2%). This resulted in a small to medium positive effect (.42) for having advanced practice nurses functioning as EBP mentors in the system.

There were significant positive correlations between planning for magnet status and number of budgeted patient beds (r = .521) (i.e., the larger number of budgeted beds, the more likely the hospital was to plan for magnet status); as well as having established RN staffing ratios (r = .51).

Recommendations from these survey findings:

Although funding to prepare new nurses and faculty is critical, there also must be funding to develop and evaluate new models of healthcare delivery and healthy work environments that result in greater work satisfaction in practicing nurses as there are high levels of turnover and dissatisfaction within the nursing profession. The cost to the healthcare system to replace one medical-surgical nurse is estimated at $46,000. The Nurse Reinvestment Act (NRA, PL 107-205) corroborates that nurse dissatisfaction contributes to the nursing shortage, and that retention could be increased and patient outcomes improved by nurse involvement in evidence-based clinical decision-making. Therefore, having advanced practice nurses as EBP mentors in hospitals to advance evidence-based practice with nurses may be one key strategy for creating satisfying work environments for them as well as improving the quality of healthcare and patient outcomes throughout our state.

We recommend a multi-site study through the Arizona Consortium for Advancement of Evidence-Based Practice (AZCAEP) to test the effects of placing advanced practice nurses as EBP mentors in various types of hospitals throughout AZ on nurse satisfaction, EBP beliefs and implementation, job satisfaction, career intentions (i.e., intent to leave), nurse turnover and vacancy rates. Positive outcomes from this study could lead to an effective solution to reduce the high vacancy and turnover rates in nursing and improve the quality of healthcare delivery in AZ and the nation.

Intensive efforts to recruit and retain nurses in correctional facilities also must be undertaken as the vacancy and turnover rates are substantially higher than in hospitals across Arizona. Nurses in these facilities also have experienced substantially less percentage of increase in their salaries since 2001 compared to hospital nurses. Most likely, nurses in other positions within the public sector (such as state agencies, public health clinics and hospitals) may have the same issues, and a more comprehensive study needs to be conducted to make a broader comparison among all types of employers.

For those Members who were not present at the August 16, 2006 meeting, this is a copy of Dr. Bethancourt's recommendation which was handed out at that meeting; pursuant to Item IV, section G of the August 16, 2006 agenda.

Psychiatric Patients the new burden of the ED
Bruce Bethancourt,M.D.
Presented to the Emergency Medical Services Access Task Force (Aug.16,2006)

Value Options (VO) is contracted to provide psychiatric care to AHCCCS patients.
Services provided by VO;

- primary payor for certain segments of the behavioral health population
- Providing actual behavioral health services, care management and providing urgent care services.

VO is considered secondary payer for patients that have commercial or Medicare coverage in addition to the AHCCCS and VO coverage. In a dual eligible situation (meaning the member qualifies for both AHCCCS and Medicare), the Medicare benefit is primary.

Value Options-Urgent Psychiatric Care (UPC) will no longer accept any patient with Medicare as primary ins. and AHCCCS or VO secondary. This includes all Seriously Mentally ILL (SMI) patients that are on Social Security Disability and Medicare.

The SMI patients on AHCCCS are normally cared for by psychiatrist with VO. If these patients decompensate and become psychotic they are brought to the emergency department instead of UPC.
Problems with bringing SMI patients to the emergency department;

- they are acutely psychotic and unable to consent to admission, transfer or discharge
- Their Value Option provider and psychiatric history are at the value option site and not available to the emergency department physician having to care for this acutely psychotic patient. The ED-physician has to treat the patient without knowledge of allergies, medications or diagnosis.
- The already overloaded EDs have become the new observation/treatment center for all acutely psychotic SMI patients of VO.

This a quality of care issue for both the psychiatric patient and the acute medically patient trying to seek medical attention in the ED.
The ED is no better at treating Psychiatric patients than a Urgent Psychiatric Center would be at treating an acute medical problem,ie.an acute myocardial infarction.

Graphs show the number of behavior health patients of VO that were brought to the emergency department and the average stay in hours from January to June of 2006.

Facility		January	February	March	April	May	June
BBMC	Behavioral (number of patients)	12	7	14	10	17	16
BDMC	Behavioral (number of patients)	23	33	27	17	36	48
	Behavioral (average bed stay hours)	5.7	6.9	2.9	2.4	3.8	5.3
BEMC	Behavioral (number of patients)	NA	NA	NA	NA	NA	NA
	Behavioral (average bed stay hours)	NA	NA	NA	NA	NA	NA
BGSMC	Behavioral (number of patients)	63	73	87	82	95	77
	Behavioral (average bed stay hours)	4.6	5.6	6.8	5.8	10.2	9.8
BMMC	Behavioral (number of patients)	7	14	11	12	8	15
	Behavioral (average bed stay hours)	4.5	7.8	7.9	5.0	5.3	10.6
BTMC	Behavioral (number of patients)	NA	NA	NA	NA	NA	NA
	Behavioral (average bed stay hours)	NA	NA	NA	NA	NA	NA

For those Members who were not present at the August 16, 2006 meeting, this is a copy of a survey handed out by Dr. Bethancourt; pursuant to Item IV, section G of the August 16, 2006 agenda.

ED SPECIALIST 2006 SURVEY

Bruce A. Bethancourt, MD,FACP.

Andrea Smiley & Melissa Alvarez (Az. Med. Assoc.)

The survey was emailed June 27, 2006 to approximately 200 specialists that are ArMA members. ArMA collected 66 survey responses. (33% response rate)

Of those who responded:
33.3% specialize in Orthopedic Surgery
29% specialize in General Surgery
12% specialize in Hand Surgery
7.5 % specialize in Gastroenterology
7.5% specialize in Neurology
6% specialize in Paleontology
4.5 % specialize in other specialties including Neurosurgery, Peripheral Vascular Surgery, and Pediatric Surgery

- Approximately 134 (67%) of respondents say they do take ED call at one or more hospitals.

- Of the 66 respondents who do take ED call (33%), approx. 33 (50%) say the ED call is subsidized by the facility or hospital at which they provide call.

Of those respondents who said that they do NOT take ED call at one or more hospitals:
Approximately 27% say that a lifestyle change is a primary reason.
Approximately 27% say that low reimbursement for services secondary to EMTALA is a primary reason.
Approximately 23% say that increased liability and exposure is a primary reason.
Approximately 23% say that their primary reason is that they are no longer required to take ED call.
Approximately 4.5% say that the primary reason is that they are no longer a member of hospital staff.
Approximately 18% gave a different primary reason for not taking ED call, including reasons such as:

Practice focusing on more elective surgery, other neurologists stopped taking call so it became an 'all or none' choice, or practice is limited to an office setting.

Dr. Tim Bonitos says that he has a 2005 statewide survey for orthopedics if you'd like to contact him for more information at bonatust@summitctr.net

COMMENTS:

1) "NO I do not take ER call. Napolitano can fend for herself now. Reasons in order I don't:
1. Lifestyle change (i.e. busies enough and do not need the headaches, including . . .
2. Increased liability and exposure, and all for . . .
3. Low reimbursement vs. no reimbursement for services.
Fortunately, my hospital has enough people it is not mandated for me, but we do have days not covered in the ER. Too bad. Get the plaintiff attorneys to do it."

"If I was not salaried and not employed by a hospital system I would not take ER call nor would I practice in Arizona, due to the lack of tort reform. I would return to Ohio where tort reform has been in effect for the past few years and statistics indicate that the number of lawsuits filed has dropped by over 50%."

#2) I will fax my survey, but I think it misses an important point. I still take call, but only about 25 % of what I used to. I stopped going to Banner Baywood hospital for only 1 reason. I didn't want to take call there. This was a multi-factoral decisison. The biggest factor was inability to take care of patients in a timely fashion. OR scheduling often required days of waiting, so that being on call one day might mean several nights of surgery. Increased liability associated with ER call was next most important factor. Lack of remuneration was the third factor. I know you didn't ask for this information, but I wanted to share.
Kip Sharpe MD
Orthopedic Surgery

Specialist Survey 2006

1. Please indicate your specialty:

____ Orthopedic Surgery
____ Hand Surgery
____ General Surgery
____ Gastroenterology
____ Neurology
____ Pulmonology
____ Other (Please list):

2. Do you take emergency department (ED) call at one or more hospitals?

___Yes
___ No – If no, please skip to question #4.

3. If you answered 'yes' above, is this subsidized by the facility or hospital at which you provide call coverage?

___Yes
___ No

(End of survey)

4. If you answered ‘no’ to question #2 - you do not take ED call, on a scale of 0 to 5, please rank the reason(s) that describe why you do not take ED call.

(0 = Not a reason, 1 = Least reason, 5 = Primary reason)

___ Lifestyle change

___ Low reimbursement for services secondary to EMTALA

___ Increased liability and exposure

___ I am no longer regarded to take ED call

___ I am no longer a member of hospital staff

___ Other reason (please list):

Austin American-Statesman
statesman.com

PRINT THIS

New study says patients with minor ailments don't crowd ERs

Lack of inpatient beds, nurses are the real problem

By Mary Ann Roser
AMERICAN-STATESMAN STAFF
Wednesday, August 23, 2006

People who jam emergency rooms with sore throats, backaches and other minor conditions do not cause crowding in ERs, contrary to conventional wisdom, a report being published today says.

The study, appearing online today in the Annals of Emergency Medicine, found that each emergency room patient with a minor ailment increased the overall stay for patients with true emergencies by 32 seconds and the treatment time by 13 seconds. Previous studies have shown that about half of all patients who come to the ER have minor ailments.

A major cause of the crowding is a lack of inpatient beds, which causes a backup of ER patients who need to be admitted to the hospital, experts said. The issue has dogged Central Texas hospitals for years.

In Austin, the Travis County Healthcare District is spending $125,000 annually for two years to help pay for an urgent care center that is opening next month adjacent to Brackenridge Hospital. Members of the health district board said they see the center as a way to ease the ER strain and cut costs.

Urgent care centers "have less expensive infrastructure and lower overall costs," said Clarke Heidrick, chairman of the district board. "That's a good reason to have an urgent care center."

Dr. Pat Crocker, chief of emergency medicine at Brackenridge Hospital and Children's Hospital of Austin, said that the study validates what he has long been saying and that he thinks the center will do little to ease ER crowding. Brackenridge, which houses the region's trauma center and has the most severe crowding in the region, directs nonurgent patients to three of the ER's 35 beds. Those patients consume few resources and little time, he said.

The bigger problem, he said, is the serious patients who need to be admitted but cannot be. "We've had as many as eight or 10 patients waiting for beds . . . and spend some part of the night there."

Brackenridge recently added 14 intensive-care unit beds, for a total of 34, and an expansion of the emergency department to 90 beds over the next two years will go a long way toward reducing the strain, he said.

In addition to the inpatient-bed crunch, hospitals use resources inefficiently and can be slow to move patients through other departments, such as X-ray, said Dr. Michael Schull, lead author of the report and a senior scientist at the Institute for Clinical Evaluative Sciences in Toronto.

"You have to accept that it's not an emergency department problem," Schull said.

He and his co-authors examined records of 4.1 million patients in 110 ERs in Ontario, Canada, for a year, ending March 31, 2003. The types of patients and hospitals were similar to those in the United States, and the findings are applicable, he said.

U.S. hospitals lost 100,000 inpatient beds in the 1990s as administrators cut costs, said Dr. Linda Lawrence, vice president of the American College of Emergency Physicians. Crowding is getting worse, threatening care for everyone and hampering the nation's ability to respond to disasters, she said.

Hospital administrators and politicians are not addressing the problem, Schull said.

Crocker said the the new urgent care center will help in a different way, by addressing the lack of primary care in the community. Sick people who wait to get care by going to the ER can be seen immediately at the urgent care center and then be directed next time to a clinic for primary care, rather than be hospitalized. The center is expected to treat about 20,000 patients a year.

"I believe this is where the real savings to the hospital and district can occur," he said.

Travis County is not alone in trying to reduce ER strain.

The Harris County Hospital District in Houston recently began routing nonurgent, indigent patients from ERs to its clinics. Those who don't leave for a clinic have to pay to be seen in the ER.

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Many health providers bypassing U.S. fund for entrant-care costs

By Lourdes Medrano

ARIZONA DAILY STAR

Emergency medical care for illegal border crossers leaves hospitals and other health-care providers with large unpaid bills, but federal officials are at a loss to explain why a controversial $1 billion federal program created to reimburse them has largely gone unclaimed.

Of a potential $47 million that health-care providers in Arizona are eligible to receive, the government has approved only $5.1 million, government figures show.

Several hospital officials in Tucson and Southern Arizona say their hospitals get reimbursed for expenses associated with treating illegal immigrants. But some noted that the complexity of what is a fairly new application process may be keeping other hospitals from seeking the funding.

"A lot of people don't think it's worth the effort," said James Dickson, chief executive officer at the Copper Queen Community Hospital in Bisbee. "It's a lot of work for 15 cents on the dollar."

For the hospital, that translates into about $400 for the monthly bill of about $4,000 that was sent to the federal government in August.

Emergency-care cost for foreign nationals totals between $50,000 and $60,000 a year at the Bisbee hospital, a drop from the roughly $450,000 it provided just a couple of years ago. Dickson attributed the decline mostly to beefed-up border enforcement, which has pushed the flow of illegal border crossers away from the area.

Although the government does not cover all expenses, Dickson said, "We're very happy we don't have to provide care for free."

University Medical Center incurred an annual loss between $4 million and $5 million treating foreign nationals in the fiscal year ending in June, said Kevin Burns, chief financial officer for the hospital. The previous year, it was about $3.5 million, he said.

And even though the funding program covers only part of the medical costs, Burns said, "it is an important recognition by the federal government that they have responsibility for the border."

It would be inappropriate to not take advantage of the funding, he said, but he acknowledged that initiating the application process can be cumbersome. "As with any new process, it was a challenge for our team to get it set up properly."

So far, UMC has received about $1.5 million in federal funding through December 2005, Burns said. "It's not covering all our costs, but we're appreciative of having some assistance."

Tucson Medical Center and Carondelet Health Network hospitals in Tucson and Nogales also have applied for the federal funding, officials said, but they could not provide specific amounts Tuesday.

Nationally, only 15 percent of the money has been handed out three-quarters of the way through the program's first year.

"We are really not certain why providers are not claiming the money," said Herb Kuhn, head of the government's Center for Medicare Management, which administers the program intended to distribute the $1 billion between 2005 and 2008.

Sen. Jon Kyl, R-Ariz., a key supporter of the funding, has been trying lately to find out why so little money has been used. "What is frustrating to me is that there is no constant response from the hospitals in Arizona to tell us what's happening," Kyl said.

In the meantime, some say the money should go elsewhere.

"Providing illegal aliens with free health care is an incentive for more illegals to come here," said Rep. Dana Rohrabacher, R-Calif., one of the louder voices today calling for tougher immigration policies.

"Draining limited health-care funds to take care of illegal aliens and reimburse hospitals for their emergency care is ill-conceived and harmful to our own citizens. I will continue to oppose this kind of nonsense," he said last week.

While federal officials search for answers for the program's slow start and say they are optimistic it will work out, hospital officials, public health experts and immigrant advocacy groups offered several explanations.

The biggest deterrent to applying for the money, they explain, is concern about time-consuming paperwork that can offset any money gained.

Another is how the government calculates costs and often dramatically trims hospital bills. Federal officials say the cuts take place because hospitals often bill for their services and not their costs, and in some cases, seek funds for longer periods of stay than allowed.

Another problem for some is more of a moral issue, a concern by hospital officials that questions about immigration status will scare off already worried immigrants.

These hospitals are uneasy with the requirement that they document whether their patients are eligible for the federal money. It's an awkward process, the hospital officials say. They are told not to ask if someone is undocumented but to seek proof of birth outside the U.S. such as a driver's license, passport or birth certificate.

And though the federal form says patients' information will not be provided to immigration officials — except in cases involving suspected terrorism or crimes — some immigrant advocacy groups and health-care providers are skeptical of such promises.

Saying it wanted to protect patients' confidentiality about their immigration status, for example, New York City's health network, the nation's largest public health system, announced in November 2005 that it would forgo the federal money.

But federal officials were not aware of New York City's position last week when initially asked why less than $100,000 has been spent so far out of the $15.1 million available in New York state. They later acknowledged the New York City hospitals' confidentiality concerns and "strong immigrant advocacy" in New York that views the documentation as "onerous."

Kyl also helped provide U.S. funds for a 2002 study that put the cost of unpaid emergency care bills for undocumented immigrants at about $190 million alone for hospitals along the nation's border with Mexico.

Hospitals' disinterest in the program comes at a time when many facilities are calling for more government support to help them deal with a growing number of poor and uninsured patients unable to pay their medical bills.

Earlier this month, the U.S. Census Bureau reported the number of uninsured Americans rose last year to a record 46.6 million, 15.9 percent of the total population. Meanwhile, the medical care that hospitals write off continues to soar.

"There are hospitals that say, 'I am only going to get 33 cents on the dollar and then I have to hire people to complete these forms and house them.' They say it's not worth the effort," said Carla Luggiero, senior associate director for federal relations at the American Hospital Association.

"On the other hand, something is better than nothing so we are going to do it. There is a schism there," she added.

On StarNet Get more information on the problem of illegal immigration and preview the Star's upcoming border series at azstarnet. com/border

• *The Chicago Tribune contributed to this story.* • *Contact reporter Lourdes Medrano at 573-4347 or lmedrano@azstarnet.com.*